Healthy Indiana Plan
PLAN SCOPE OF WORK

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1.0 Plan Administrative Requirements

1.1 The Program

The health care coverage plan established under House Bill 1678 (the "Program") extends health care coverage to certain low-income, uninsured Hoosiers without access to employer sponsored health insurance. The Program is designed to foster personal responsibility, promote preventative care and healthy lifestyles while encouraging participants to be value conscious consumers of health care to help promote price and quality transparency. The Program will be financed by a combination of State cigarette tax revenue, potential Federal Medicaid funds, individual contributions and other funds. It received legislative approval under HB No. 1678 and is awaiting federal approval of a Section 1115 waiver demonstration proposal. If approved, the Section 1115 waiver will exempt the Program from application of certain parts of Title XIX of the Social Security Act of 1935, an act which governs Medicaid and is a condition to the receipt of Federal Medicaid funds.

Under the Program, the State of Indiana wishes to contract with statewide, risk-bearing entities to deliver a basic benefit package offered through a deductible health plan paired with a personal health care account referred to as a POWER (Personal Wellness and Responsibility) Account. The deductible health plan includes up to $500 of "first dollar" coverage for preventative services in order to eliminate barriers to obtaining preventative care. The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at minimum, be funded with State and individual contributions. Employers may contribute as well with some restrictions. Members will use POWER Account funds to meet the deductible of their deductible health plan. However, POWER Accounts will be funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under federal law. Therefore, they are not subject to regulation under the U.S. Tax Code as such.

The Program is designed to operate as a public-private partnership for expanding health insurance to Hoosiers who currently lack health care coverage and do not have access to employer-sponsored health insurance. It is estimated that over 350,000 Hoosiers are potentially eligible for the Program; however, the number of participants will depend on available funding because the Program is not an entitlement program.

The Office of Medicaid Policy and Planning (OMPP) intends to contract with one or more accident and sickness insurers or HMOs (i.e., the "Plan") to deliver the deductible health plan and POWER Account to individuals eligible in the Program. Plans participating in the Program must be licensed as risk-bearing entities under Title 27 of the Indiana Code and will assume financial risk for establishing and managing comprehensive provider networks for the delivery of health care services to members enrolled in the Program.

It is the intent of OMPP to contract with Plans committed to the promotion of personal responsibility, healthy behaviors, preventative care and cost and quality transparency. The Program represents a groundbreaking attempt to expand coverage while encouraging individuals to take a more proactive role in managing their health and the cost of their health care. The Program's design will be looked to as a model by other states grappling with ways to reduce the number of uninsured, and Plans are strongly encouraged to submit creative proposals for addressing the Program's goals beyond the minimum requirements set forth in the RFS and this Attachment. A major feature of the Program is innovation, and the State hopes that participating plans will see the Program as an opportunity to design a plan that provides incentives for staying healthy, being value- and cost-conscious and utilizing services in a cost-efficient manner.

Because the Program is financed in part by Federal Medicaid funds, Plans participating in the Program must meet all applicable requirements of Medicaid managed care organizations (MCOs) under Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438. Plans must also ensure that its network providers, including out-of-state providers, enroll in the Indiana Health Coverage Programs (IHCP) before they start providing health care services to members enrolled in the Program. Further information about IHCP Provider Enrollment is located at:

http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp

1.1.1 Buy-In Product

Pursuant to IC 12-15-44, a Plan, or the affiliate of a Plan, that contracts with OMPP to offer State-subsidized health care coverage under this RFS to individuals eligible for the Program must also make the same health insurance available for purchase by an individual who:

- Has not had health insurance coverage for the previous six (6) months; and
- Although eligible for state-subsidized coverage under the Program (i.e., has income under 200% of the FPL and meets other Program eligibility requirements), is unable to enroll in the Program at the time of application because the annual state appropriation for the Program has been exhausted and the State has temporarily stopped accepting new members into the Program. See IC 12-15-44-15.

In offering individuals eligible for, but unable to enroll in, the Program an opportunity to buy the same health insurance provided to participants in the Program, the Plan must ensure that the underwriting and rating practices applied are no different from the underwriting and rating practices used for the health insurance coverage provided to participants in the Program.

The Plan, or an affiliate of the Plan, is also required to make the same health insurance provided under this RFS available for purchase by other individuals (i.e., individuals with incomes above 200% of the FPL), so long as the individual has not had health insurance coverage during the previous six (6) months. In offering coverage to individuals with incomes above 200% of the FPL, the Plan may apply its standard individual or small group insurance underwriting and rating practices.

The State will provide no funding to the Plan for offering the groups identified in this Section an opportunity to buy into the same health insurance it provides under the Program pursuant to this RFS.

If the Plan provides an opportunity for individuals to purchase the same health insurance available under this RFS through an affiliate of the Plan, the Plan will be required to enter into a subcontract with the affiliate. The subcontract will be subject to the subcontracting requirements set forth in Section 1.6 of this Attachment, and the affiliate of the Plan will be bound by the same requirements the Plan would be bound by had the Plan provided its product under the Program for purchase directly and not through the affiliate.

1.2 Administrative Structure of the Plans

Plans will be required to maintain an administrative and organizational structure that supports effective and efficient delivery of services to members enrolled in the Program. The Plan's administrative and

organizational structure must also support collection and integration of data from every aspect of the Plan's delivery system and internal functional units for the purpose of accurately reflecting Plan performance. The Plan will be required to have policies and procedures in place that support the integration of financial and performance data according to applicable Federal and State requirements.

Prior to the contract effective date, OMPP will provide a series of orientation sessions to assist the Plan in developing its internal operations to support the requirements of the Plan's contract with the State (e.g., POWER Account administration, data submission, data transmissions, reporting formats, etc.).

The Plan must have in place sufficient administrative and clinical staff and organizational components to comply with all of the Program's requirements and standards. The Plan must manage the functional linkage of major operational areas, including:

- Administrative and fiscal management
- Marketing
- Member services
- Provider services
- Provider enrollment
- Network development and management
- Quality management and improvement
- Utilization management
- Physical health
- Mental health
- POWER Accounts
- Information systems (e.g., claims processing and data reporting)

1.3 Staffing

The Plan will be required to have sufficient key staff to ensure that the Plan complies with the Program's requirements and standards and has the ability to manage the major operational areas identified in Section 1.2 above. The Plan must designate a Compliance Officer pursuant to 42 CFR 438.608(b)(2), in addition to any other staff required under its license with the Indiana Department of Insurance (IDOI).

The Plan must maintain a high level of plan performance and data reporting capabilities regardless of staff vacancies or turnover. The Plan must have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

The Plan must have an office in the State of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities and a major portion of the Plan's operations take place.

In addition to attendance at any vendor meetings scheduled by the State, all key staff must be accessible to OMPP and its subcontractors via voicemail and electronic mail systems. As part of its annual Quality Management and Improvement Plan, the Plan must submit to OMPP an updated organizational chart including e-mail addresses and phone numbers for key staff.

The Plan must have written job descriptions for key personnel that will oversee the activities discussed in Sections 1.3.1 and 1.3.2 below. Responsibilities and required qualifications—including education,

professional credentials and work experience—should be included in the job description. Resumes for key personnel must be available upon request.

1.3.1 Key Contact

The Plan is required to provide a key contact person and establish a defined escalation policy for all issues, questions and concerns that the State, OMPP or any of its subcontractors may have pertaining to services provided by the Plan pursuant to the Plan's contract with the State under this RFS. The Plan must provide written notification to OMPP of anticipated changes in this key contact. The State reserves the right to approve any candidates and subsequent replacements to this position.

1.3.2 Staffing Plan

The Plan must develop a staffing plan that meets the minimum responsibility requirements listed below. This staffing plan will be one of the criteria of technical and qualitative assessment for all RFS respondents.

- **Administrative Responsibilities**
    - Plan management
    - Plan contract compliance
    - Plan budget oversight
    - Plan accounting oversight
    - Plan financial performance oversight
    - Plan financial reporting oversight
    - Establishment of a grievance and appeals process
- **Compliance Responsibilities**
    - Compliance plan development and oversight
    - Fraud and abuse reporting in accordance with 42 CFR 438.608
    - Federal and State legislation, legislative initiatives and regulations expertise
    - Plan performance reporting requirements
- **Information Systems Responsibilities**
    - Oversight of the Plan's Information System (IS) for the Program
    - Liaison between the Plan and the State's fiscal agent, monitoring contractor, or other OMPP contractors regarding capitation payment, utilization, encounter and claims data, member eligibility and enrollment, POWER Account operations and other data transmission, interface, and management issues
    - Compliance and quality for all data transactions
    - Adherence to IS program requirements specified in Section 7.0 of this Attachment.
    - Provide and maintain e-mail accounts for members

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- **Medical Responsibilities**

    - Development and implementation of the Plan's clinical practice guidelines
    - Physical health care services
    - Mental health care services
    - Disease Management
    - Quality of care management
    - Clinical management program oversight
    - Interface with the Plan's primary medical providers (PMPs) and specialty providers
    - Direction of the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions and other quality management, utilization management or program integrity activities

- **Member Services Responsibilities**

    - Direction of the activities of the Plan's member services, including, but not limited to, marketing, member helpline telephone performance, member education, outreach programs and marketing and member materials development, approval and distribution
    - Management of the grievance and appeals process
    - Member enrollment and disenrollment management
    - Member utilization of preventative care services, including reminders and other outreach
    - Orientation and on-going training for all helpline and support representatives
    - Coordination with POWER Account responsibilities, particularly POWER Account balance inquiries by members and member questions, issues or concerns regarding their POWER Account

- **Provider Services Responsibilities**

    - Provider helpline performance
    - Provider recruitment, contracting and credentialing
    - Claims dispute processing
    - Provider education, outreach and manual development and distribution
    - Provider network information
    - Adherence to the provider requirements in Section 5.0 of this Attachment

- **Quality Management Responsibilities**

    - Direction of Quality Management staff
    - Health care delivery system audits, including but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality

- Adherence to the Quality Management requirements in Section 6.1 of this Attachment (these requirements are based on the federal regulations set forth in 42 CFR 438, Subpart D)

- **Utilization Management Responsibilities**

  - Direction of staff regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination and other medical management programs
  - Adherence to the Utilization Management requirements in Section 6.2 of this Attachment (these requirements are based on the federal regulations set forth in 42 CFR 438, Subpart D)

- **POWER Account Responsibilities**

  - POWER Account operations and administration
  - Billing and collecting member and employer contributions
  - Issuing "POWER Account cards"
  - Monitoring member compliance with preventative service recommendations
  - Account roll-over and rebates
  - Recalculation of required individual contributions when POWER Account funds are rolled over at the end of a coverage term
  - Account balance inquiries
  - Electronic EOB statements
  - Adherence to the POWER Account requirements and responsibilities set forth in Section 3.0 of this Attachment

- **Pharmacy Management Responsibilities**

  - Compliance with all State and Federal pharmacy requirements

1.3.3 Training

On an ongoing basis, the Plan must ensure that each staff person, including subcontractors' staff, has appropriate and ongoing training (e.g., orientation, cultural sensitivity, Program background, Program updates, clinical protocols, policies and procedures compliance, management information systems, POWER Accounts, training on fraud and abuse and the False Claims Act, etc.), education and experience to fulfill the requirements of their position. The Plan must maintain documentation to confirm its internal staff training, curricula, schedules and attendance and must provide this information to OMPP and/or its monitoring contractor upon request.

1.3.4 Debarred Individuals

In accordance with 42 CFR 438.610, the Plan must not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above

Relationships include directors, officers, or partners of the Plan, persons with beneficial ownership of five percent or more of the Plan's equity, or persons with an employment, consulting or other arrangement with the Plan for the provision of items and services that are significant and material to the Plan's obligations under its contract with the State.

In accordance with 42 CFR 438.610, if OMPP finds that the Plan is in violation of this regulation, OMPP will notify the Secretary of noncompliance and determine if the agreement will continue to exist.

1.4 OMPP Meeting Requirements

OMPP reserves the right to conduct meetings and collaborative workgroups for the Program. Plans will be required to comply with all meeting requirements established by the State, according to a schedule set forth by the State. Plans will be expected to cooperate with OMPP or its subcontractors in preparing for and participating in required meetings. If OMPP makes changes to Plan meeting requirements, this cannot result in a change order request under this RFS from the Plan.

In addition, OMPP reserves the right to meet at least annually with the executive leadership of each Plan to review the Plan's performance, discuss the Plan's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the Plan or the program.

1.5 Financial Stability

The Plan must meet and comply with all requirements located in Title 27, Articles 1 through 15, of the Indiana Code. This includes, but is not limited to, the requirements pertaining to financial solvency, reinsurance and policy contracts, as well as administration of these processes.

OMPP and IDOI will monitor the Plan's financial performance and require financial indicator reporting. OMPP must be copied on required filings with IDOI. A list of required IDOI filings is provided in Section 8.1 of this Attachment.

1.5.1 Solvency

The Plan must maintain a fiscally solvent operation per Federal regulations and IDOI's requirements for a minimum net worth and risk-based capital.

The Plan must comply with the Federal requirements for protection against insolvency pursuant to 42 CFR 438.116. These requirements provide that, unless the Plan is a Federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Plan must:

- Provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that enrollees will not be liable for the Plan's debts if the entity becomes insolvent

- Meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity

1.5.2 Financial Accounting Requirements

The Plan must maintain accounting records that are specific to the Program's operations and are in accordance with IDOI requirements. The Plan must maintain accounting records specifically for performance of the contract under this RFS that incorporate performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors.

In accordance with 42 CFR 455.100-104, the Plan must notify OMPP of any person or corporation with five percent or more of ownership or controlling interest in the Plan and must submit financial statements for these individuals or corporations.

Authorized representatives or agents of the State and the Federal government must have access to the Plan's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of this contract for purposes of review, analysis, inspection, audit and/or reproduction.

Copies of any accounting records pertaining to the contract must be made available by the Plan within 10 calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the Plan must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal offices of the Plan or other locations of such records. FSSA, OMPP, IDOI and other State and Federal agencies and their respective authorized representatives or agents must have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other State or Federal agency connected with the contract.

The Plan must maintain financial records pertaining to the contract, including all claims records, for three years following the end of the Federal fiscal year during which the contract is terminated, or when all State and Federal audits of the contract have been completed, whichever is later, in accordance with 45 CFR 92.42. Financial records should address matters of ownership, organization and operation of the Plan's financial, medical and other record keeping systems. Accounting records pertaining to the contract must be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract if the litigation has not terminated within the three-year period.

1.5.3 Reporting Transactions with Parties in Interest

Any Plan that is not a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act) must disclose to OMPP information on certain types of transactions they have with a "party in interest," as defined in the Public Health Service Act. (See §§1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act.) For purposes of this RFS, the following reporting

requirements will apply to all Plans in the same manner that they apply to HMOs under the Public Health Service Act.

Definition of a Party in Interest.--As defined in §1318(b) of the Public Health Service Act, a party in interest is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent of the HMO; and, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

- Any entity in which a person described in the paragraph above is director or officer; partner; has directly or indirectly a beneficial interest of more than five percent of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; and

- Any spouse, child, or parent of an individual described above.

Types of Transactions Which Must Be Disclosed. -- Business transactions which must be disclosed include:

- Any sale, exchange or lease of any property between the HMO and a party in interest;

- Any lending of money or other extension of credit between the HMO and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between a Plan and a party in interest listed above includes:

- The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;

- The accrued dollar value of each transaction during the fiscal year; and

- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, the Plan may be required to submit a consolidated financial statement for the Plan and the party in interest.

1.6 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Plan and health care providers or other ancillary medical providers. The term "subcontract(s)" also includes contracts between the Plan and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the State's contract with the Plan and any administrative entities not involved in the actual delivery of medical care. Additionally, as specified in Section 3, any entity contracted to administer or host the POWER Accounts or to provide any point of sale infrastructure will be considered a subcontractor. Affiliates of the Plan that offer the same health insurance provided under this RFS to individuals for purchase, pursuant to IC 12-15-44-15 and 16, will also be considered subcontractors.

OMPP must approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements. The State may waive its right to review subcontracts and material changes to subcontracts. The State encourages the Plan to subcontract with entities that are located in the State of Indiana, and will give additional points during the bidding process to Plans that use Indiana-based subcontractors. See Section 2.7 of the RFS, "Buy Indiana," for additional detail.

According to IC 12-15-30-5, subcontracts cannot extend beyond the term of the contract between the Plan and the State.

The Plan is responsible for the performance of any obligations that may result from this RFS. Subcontractor agreements do not terminate the legal responsibility of the Plan to the State to ensure that all activities under the contract are carried out. The Plan must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the Plan's monitoring activities. The Plan will be held accountable for any functions and responsibilities that it delegates.

Plans that subcontract with prepaid health plans, physician-hospital organizations or another entity that accepts financial risk for services the Plan does not directly provide must monitor the financial stability of the subcontractor(s) whose payments are equal to or greater than five percent of premium/revenue. The Plan must obtain the following information from the subcontractor at least quarterly and use it to monitor the subcontractor's performance:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- IBNR estimates

At least annually, the Plan must obtain the following information from the subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance and an actuarial opinion of the IBNR estimates. The Plan shall make these documents available to OMPP upon request and OMPP reserves the right to review these documents during Plan site visits.

The Plan must also comply with 42 CFR 438.230 and the following subcontracting requirements:

- The Plan must obtain the approval of OMPP before subcontracting any portion of the project's requirements. The Plan must give OMPP a written request and submit a draft contract or model provider agreement at least 60 calendar days prior to the use of a subcontractor. If the Plan makes subsequent changes to the duties included in the

subcontractor contract, it must notify OMPP 60 calendar days prior to the revised contract effective date and submit the amendment for review and approval. OMPP must approve changes in vendors for any previously approved subcontracts.

- The Plan must evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform Program related services.

- The Plan must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement must be in compliance with all State of Indiana statutes, and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's contract with the Plan.

- The Plan must collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews, as directed by OMPP. The Plan must incorporate all subcontractors' data into the Plan's performance and financial data for a comprehensive evaluation of the Plan's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Plan must take corrective action if deficiencies are identified during the review.

- All subcontractors must fulfill all State and Federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors must fulfill the requirements of the State's contract with the Plan (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.

- The Plan must comply with all subcontract requirements specified in 42 CFR 438.230. All subcontracts, provider contracts, agreements or other arrangements by which the Plan intends to deliver services required under this RFS, whether or not characterized as a subcontract under this RFS, are subject to review and approval by OMPP and must be sufficient to assure the fulfillment of the requirements of 42 CFR 434.6. OMPP may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement. In accordance with IC 12-15-30-5(b), subcontract agreements for Program-related activities terminate when the Plan's contract with the State terminates.

The Plan must have policies and procedures addressing the auditing and monitoring of subcontractors' data, data submissions and performance. The Plan must integrate subcontractors' financial and performance data (as appropriate) into the Plan's information system to accurately and completely report Plan performance and confirm contract compliance.

OMPP reserves the right to audit the Plan's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. OMPP may require corrective actions and may assess liquidated damages, as specified in Section 9.1.2 of this Attachment, for non-compliance with reporting requirements and performance standards.

If the Plan uses subcontractors to provide direct services to members, the subcontractors must meet the same requirements as the Plan, and the Plan must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The Plan must require subcontractors providing

direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

While the Plan may choose to subcontract claims processing functions, or portions of those functions, with a State-approved subcontractor, the Plan must demonstrate that the use of such subcontractors is invisible to providers, and will not result in confusion to the provider community about where to submit claims for payments.

1.7 Confidentiality of Member Medical Records and Other Information

The Plan must ensure that its member's medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160 and 164, subparts A and E). The Plan must also comply with all other applicable State and Federal privacy and confidentiality requirements.

1.8 Future Program Guidance

The Program is a new Indiana Family & Social Services Administration (FSSA) program, and at the time of issuing this RFS, the State is in the process of drafting one or more program manuals that will be used to administer the Program. These program manuals will be used to assist Plans in complying with the Program requirements, and may describe in further detail the services required in this RFS. Plans must operate in compliance with these future Program manuals, as well as any amendments thereto. The State and Plans will agree in writing to program manual modifications that have a significant impact on Plan requirements and impact the scope of work.

2.0 Covered Benefits and Services

The Plan must deliver all medically necessary covered benefits and services in a manner that is reasonably expected to achieve the purpose of the furnished services. Costs for these services are the basis of the Plan's capitation rate and are, therefore, the responsibility of the Plan. Coverage may not be arbitrarily denied or reduced, but may be subject to certain limitations in accordance with 42 CFR 438.210(a)(3)(iii) regarding:

- Medical necessity determinations.
- Utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

A covered service is medically necessary if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to:

- Prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability.
- Cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury, or disability.
- Reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability.

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As stated in IC 12-15-44-4, the Plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana. Covered services under the Program include, at minimum, all services identified in IC 12-15-44, which are as follows:

- Mental health care services
- Inpatient hospital services
- Prescription drug coverage
- Emergency room services
- Physician office services
- Diagnostic services
- Outpatient services, including therapy services
- Comprehensive disease management
- Home health services, including case management
- Urgent care center services
- Preventative care services
- Family planning services, as set forth in Section 2.1 of this Attachment
- Hospice services
- Substance abuse services

The Plan must also cover lead screening and hearing aids for 19 and 20 year old members.

Attachment E of this RFS describes covered services and the Program's benefit package in further detail. Vision and dental services are not part of the basic benefit package under the Program.

Plans must reimburse providers, for covered services at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate.

The Plan will be paid a capitation rate only for providing those covered services and administrative features described in this RFS and its Attachments. This RFS and its Attachments represents the minimum requirements; however, the Plan is largely free to design its product under the Program as it sees fit within this capitation rate. For instance, the Plan may provide an out-of-network benefit beyond the requirements of Sections 2.1 and 2.5 of this Attachment, may cover brand name drugs and/or may provide enhanced benefits beyond the requirements of this Attachment.

The Plan must develop procedures to monitor and assess its effectiveness in delivering quality health care to its members under the Program. The Plan may be required to submit performance data related to its medical necessity determinations and utilization management, as determined by the State. The State reserves the right to audit the Plan's utilization management and medical necessity determination process at any time. As provided in IC 12-15-44-3, OMPP will adopt quality of care standards for the Program, and the Plan will be required to comply with these standards.

The Plan must have policies and procedures that demonstrate how the Plan integrates all health care delivery services and activities with the Plan's Quality Management and Improvement Program described in Section 6.1 of this Attachment.

2.1 Self-Referral Services

In accordance with Federal requirements, the Program includes some benefits and services that are available to members of the Program on a self-referral basis. These self-referral services cannot require a

referral from the member's PMP or authorization from the Plan. The following services are considered self-referral services:

- Family planning services. Federal regulation 42 CFR 431.51(b)(2) requires a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills and non-oral contraceptives. Family planning services also include sexually transmitted disease testing. Elective abortions and abortifacients are not covered family planning services.

  Members under the Program may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Plan's contracted network. Members under the Program may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider.

  The Plan must allow its members to obtain birth control pills and non-oral contraceptives on a self-referral basis. OMPP recognizes the need for appropriate management of prescription medication in the interest of the member's health; however, OMPP also recognizes the importance of removing barriers to family planning services. To reduce potential barriers to obtaining birth control pills, the Plan must, at a minimum, reimburse for the dispensation of up to a 90 calendar day supply of birth control pills at one time per member, if prescribed.

- Emergency services. Emergency services are covered without the need for prior authorization or the existence of a provider agreement with the emergency care provider. Emergency services must be available 24 hours a day, seven days a week, subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114. See Section 2.2 of this Attachment for more information.

The Plan must include self-referral providers in its contracted network. The Plan and its PMPs may direct members to seek the services of the self-referral providers contracted in the Plan's network, but the Plan cannot require that the members receive such services from network providers. When members choose to receive self-referral services from providers who do not have contractual relationships with the Plan, the Plan is responsible for payment to these providers up to the applicable benefit limits and at Program rates (i.e., Medicare rates).

2.2 Emergency Care

2.2.1 Emergency Services

The Plan must cover and pay for all emergency room visits, regardless of whether the prudent layperson standard is met. Co-payments will apply to emergency room visits, as set forth in Section 2.2.3, below.

The Plan must cover and pay for emergency services and poststabilization care services according to 42 CFR 438.114. The Plan must cover these services without the need for prior authorization or the existence of a Plan contract with the emergency care provider. Services for treatment of an emergency medical condition, as provided in 42 CFR 438.114, must be available 24 hours a day, seven days a week.

Emergency services are covered inpatient and outpatient services necessary to evaluate or stabilize an emergency medical condition. An "emergency medical condition" is defined in 42 CFR 438.114(a) as: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

The Plan must cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, provided to members who presents to an emergency department with an emergency medical condition. If this screening exam leads to a clinical determination by the physician that an emergency medical condition exists, the Plan must pay for both the screening and any services required to stabilize the patient. If the screening does not uncover an emergency medical condition, the Plan must still pay for the screening examination if, after reviewing the member's presenting symptoms, the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

The Plan must reimburse out-of-network emergency services providers at 100 percent of the Program's rates (i.e., Medicare rates or 130% of Medicaid rates), minus any applicable co-payments.

In accordance with 42 CFR 438.114, the Plan may not determine what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The Plan may not deny payment for treatment obtained when an enrollee had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition. The Plan may not deny or pay less than the allowed amount for the CPT code on the claim without a medical record review. As stated in 42 CFR 438.114(d)(ii), the Plan is prohibited from refusing to cover emergency services, even if the emergency room provider, hospital, or fiscal agent does not notify the member's PMP or the Plan of the member's screening and treatment within 10 calendar days of presentation for emergency services. The member who has an emergency medical condition is not liable for the payment of subsequent screening and treatment that may be needed to diagnose or stabilize the specific condition, with the exception of applicable co-payments. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The physician's determination is binding and the Plan may not challenge the determination.

The Plan must demonstrate to OMPP that it has the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- A mechanism in place for a Plan provider or Plan representative to respond within one hour to all emergency room providers 24 hours a day, seven days a week. The Plan will be financially responsible for the post-stabilization services if the Plan fails to respond to a call from an emergency room provider within one hour.

- A mechanism to track the emergency services notification to the Plan (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services

- A mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly

2.2.2 Post-Stabilization

As described in 42 CFR 438.114(e), the Plan must cover post-stabilization services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition. The Plan must demonstrate to OMPP that it has a mechanism in place to be available to all emergency room providers 24-hours-a-day, seven-days-a-week to respond within one hour to an emergency room provider's request for authorization of continued treatment after the Plan's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

2.2.3 Emergency Room Services Co-Payment

A co-payment will apply to emergency room services. Providers will collect the co-payment from members, and, as specified in Section 3.2.1 of this Attachment, POWER Account funds cannot be used by the member to pay the co-payment.

Childless adults will be subject to a $25 co-payment for all ER visits. The co-payment must be waived or returned by the plan if the person is admitted to the hospital on the same day as the visit. The plan may waive or return the copay to the POWER account or the person.

Parents will also be subject to a co-payment for emergency room services, according to the following schedule:

- < 100% FPL - $3
- 100-150% FPL - $6
- 151-200% FPL - 20% of the cost of the services provided during the visit, or $25, whichever is less

The co-payment must be waived or returned if the parent is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act, or if the person is admitted to the hospital on the same day as the visit. The plan may waive or return the copay to the POWER account or the person.

The member must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act.

Assuming a member has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the member before providing non-emergency services that:

- The hospital may require payment of the co-payment before the service can be provided;
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
- An alternate provider can provide the services without the imposition of the co-payment;
- The hospital provides a referral to coordinate scheduling of this treatment.

Without interfering with member access to emergency care, Plans are encouraged to design creative strategies for reducing unnecessary emergency room utilization. Depending on the Plan's membership, example strategies could include, but are no way limited to, education and outreach, 24-hour nurse hotlines and contracting with after-hours urgent care centers.

2.3 Preventative Care Services

The Program is designed to facilitate access to, and emphasize the importance of, preventative care. Contrary to most deductible plans, Program benefits include $500 of "first dollar" coverage for preventative care services. Such services are not subject to the deductible and no additional cost sharing applies. Members can use the $500 preventative care benefit to cover routine preventative services such as mammograms, colorectal screenings, smoking cessation classes, etc. Each year, OMPP will identify which preventative services will be covered in the $500 of "first dollar" coverage. Members can receive additional preventative services beyond the $500 threshold, but these services will be subject to the deductible. "Preventative care services" means care that is provided to an individual to prevent disease, diagnose disease or promote good health.

In an effort to further encourage members to obtain preventative care services, OMPP will determine recommended preventative services for members in each age and sex category, as well as recommended preventative services based on members' pre-existing conditions. Members that obtain recommended preventative services will be able to roll-over the entire balance, if any, in their POWER Account at the end of a coverage term. This incentive is described in further detail in Section 3.0 of this Attachment. Plans are encouraged to establish additional incentives, in addition to account roll-over, to help increase preventative service utilization.

The Plan will be required to send member reminders about obtaining recommended services. Other innovative proposals to help achieve member compliance with recommended preventative care is highly desired.

Examples of OMPP recommended preventative care services for members in each age and sex category is described on the following page.

Preventative Care Service	Male 19-34	Female 19-34	Male 35-49	Female 35-49	Male 50-64	Female 50-64
Colonoscopy					✓	✓
Annual Physical	✓	✓	✓	✓	✓	✓
Flu Shot					✓	✓
Pap Smear		✓		✓		✓
Cholesterol Testing			✓	45+	✓	✓
Mammogram				✓		✓
Chlamydia Screening		Under 25				
Blood Glucose Screening	✓	✓	✓	✓	✓	✓
Tetanus-Diphtheria Booster	✓	✓	✓	✓	✓	✓

2.4 Excluded Services

2.4.1 Pregnancy and Related Services

The Program excludes pregnancy and related services from its covered services. In fact, when a member becomes pregnant, she will be disenrolled from the Program and the Plan and will be enrolled in Hoosier Healthwise instead. The woman will have the opportunity to re-enroll in the Program after her pregnancy has concluded.

Plans must have policies and procedures in place for identifying pregnant members and helping them enroll in Hoosier Healthwise. These policies and procedures must establish that the Plan will inform both the member and the provider of the procedure to get enrolled in Hoosier Healthwise and also provide the necessary forms to enroll in Hoosier Healthwise. The Plan must submit a monthly report to the State identifying all members that have had rejected pregnancy claims; this report must include the RID number. . The Plan must also have a process for following up with pregnant members to make sure they successfully obtain Hoosier Healthwise coverage. It is highly desirable that the Plan employ innovative methods to both identify pregnant members and ensure their early access to Hoosier Healthwise coverage. Once a woman is enrolled in Hoosier Healthwise, she will be disenrolled from the Program and the Plan. . The woman will remain enrolled in Hoosier Healthwise until the completion of her postpartum period. The Plan's liability for covering a pregnant member continues until the State informs the Plan

that the member has been enrolled in Hoosier Healthwise. The State will determine the member's termination date from the Plan and notify the Plan of the termination date. In the interim, the Plan may reject pregnancy-related claims (as defined by the State), but must cover all other services. The Plan must advise providers that the State will pay all pregnancy-related claims incurred during the pregnancy discovery period (up to three months) (based on date of service) on a fee-for-service basis, and that pregnancy eligibility must be established within the fiscal agent's system prior to claims submission. In addition the Plan must 1) provide a written explanation to providers with any rejected claim that informs them to redirect the claim to the State and submit proof of pregnancy to the State per current Hoosier Healthwise requirements, 2) assure providers are given access to the Medicaid RID number for the member and, 3) complete any other responsibilities that may be required to initiate the transfer of a pregnant member to Hoosier Healthwise.

Plans will inform members, in writing, that in order to receive coverage for their pregnancy, they must switch coverage to Hoosier Healthwise. The Plans will inform members that in order to qualify for Hoosier Healthwise pregnancy coverage, verification of pregnancy must be provided to DFR. Acceptable verification is a signed statement from a licensed health professional that includes:

1) Confirmation of pregnancy;
2) the anticipated date of delivery; and
3) if multiple births are expected.

If multiple births are expected, this information should also be included as it affects the income standard used in the eligibility determination.

The Plan will faciliate getting this documentation or the member can take care of it herself. Pregnant members can call the DFR Service Center to report the pregnancy. DFR may then send her the change report form that she can attach to her doctor's statement or she can be given the Document Center's address to mail or fax the doctor's statement. DFR will then close the Healthy Indiana Plan case and approve Hoosier Healthwise.

A member shall not be transferred from the Plan to Hoosier Healthwise if the first pregnancy-related claim incurred is for spontaneous abortion or any expense related to a termination of pregnancy. In this situation, the member shall remain enrolled in the Plan and the Plan shall pay for this expense. Therefore, the State is defining pregnancy-related claims as those indicative of active pregnancies and/or deliveries of a living fetus.

Additional guidelines regarding the Plan's responsibility to help pregnant members obtain Hoosier Healthwise coverage will be developed by the State and published in a future program manual and/or administrative rule. The Plan will be required to follow these guidelines.

2.4.2 Vision and Dental Services

Vision and dental services are not part of the basic benefit package under the Program.

2.5 Continuity of Care

The Program established under HB 1678 is committed to providing continuity of care for members as they transition between various health coverage programs. The Plan must have mechanisms in place to

ensure the continuity of care and coordination of medically necessary health care services for its members under the Program. The State emphasizes several critically important areas where the Plan must address continuity of care. Critical continuity of care areas include, but are not limited to:

- A member's transition between Plans within the Program, particularly during an inpatient stay. (As described in Section 4.1.5 of this Attachment, members will be permitted to change plans at the end of each 12-month coverage term.)

- A member's transition from the Plan to the State's high-risk plan for enrollees with high-risk health conditions or from the State's high- risk plan to the Plan.

- A member's transition from the Program to another FSSA program or private insurance, including a pregnant woman's transition to Hoosier Healthwise.

- A member's transition from the Program to no coverage.

In situations such as a member or PMP disenrollment from the Plan, the Plan must facilitate care coordination with other health plans or other PMPs. When receiving members from another health plan or the State's high-risk plan for enrollees with high-risk health conditions, the Plan must honor the previous entity's care authorizations for a minimum of 30 calendar days.

The Plan will be responsible for care coordination if a member is disenrolled from the Plan whenever the member disenrollment occurs during an inpatient stay. In these cases, the Plan will remain financially responsible for the hospital DRG payment (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in the Program terminates. The Plan must coordinate discharge plans with the member's new health plan, if applicable.

2.6 Out-of-Network Services

With the exception of certain covered services—family planning services and emergency medical services—the Plan may limit its coverage to services provided by in-network providers only. However, in accordance with 42 CFR 438.206(b)(4), the Plan must authorize and pay for out-of-network care if the Plan is unable to provide necessary covered medical services within 60-miles of the member's residence by the Plan's contracted provider network. The Plan must authorize these out-of-network services in the timeframes established in Section 6.2.1 of this Attachment and must adequately cover the services for as long as the Plan is unable to provide the covered services in-network. The Plan must require out-of-network providers to coordinate with the Plan with respect to payment and ensure that the cost to the member is no greater than it would be if the services were furnished in-network.

Out-of-network claims must be paid at established Program rates, i.e., Medicare fees in effect on the date of the service. If Medicare does not have an established rate for the covered service, the Plan must pay the out-of-network claim at 130% of the Medicaid rate for that service.

Plans participating in the Program must make nurse practitioner services available to members. Members must be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the member's service area within the Plan's network. If nurse practitioner services are available through the Plan, the Plan must inform the member that nurse practitioner services are available.

For family planning services, emergency medical services, nurse practitioner services and cases where the Plan is unable to provide necessary covered services within 60-miles of the member's residence by the

Plan's contracted provider network, the Plan may not require an out-of-network provider to acquire a Plan-assigned provider number for reimbursement. An IHCP provider number or Federal tax ID shall be sufficient for out-of-network provider reimbursement in these cases.

2.7 Mental Health Care Services

IC 12-15-44-4 provides for full mental health parity in the Program's covered services. The Plan must not apply treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

2.8 Disease Management

At minimum, the Plan must make disease management programs available to members in the Program with the following conditions: Diabetes, Congestive Heart Failure, Asthma and Chronic Kidney Disease. The Plan is encouraged to implement additional disease management programs, and Plans are free to design the disease management programs as they see fit. The State intends that the Plan's disease management programs will serve as a critical area for pursuing continuous innovation in improving member health status.

All disease management programs must encourage compliance with care guidelines and incentivize healthy member behaviors. Potential incentives may include the establishment of a separate health care account to be used to pay for non-covered health care services and benefits, such as over-the-counter drugs, vitamins and other health care products and services.

OMPP reserves the right to examine the Plan's disease management programs at any time, including during the proposal review process, prior to contract execution and during the readiness review.

The Plan must report at least annually to OMPP regarding the effectiveness and results of its disease management programs. OMPP will use the data to monitor the efficacy of the programs.

OMPP reserves the right to require the Plan to establish disease management programs for additional conditions in the future. OMPP will provide three (3) months' advance notice to the Plan if OMPP decides to establish additional disease management program requirements.

If the Plan provides additional disease management programs, the Plan must substantiate the reasons for initiating such programs, must secure OMPP's approval for implementing the additional disease management program(s) and must provide annual updates documenting the efficacy and results of the additional disease management programs.

2.9 Enhanced Services

The State encourages the Plan to cover additional services that enhance the general health and well being of its membership, especially services that address preventative health care needs, personal responsibility and cost and quality transparency. Enhanced services are above and beyond those services covered in the Program and should help advance the Program's goals. Enhanced services are an area in which the Plan can distinguish itself from competing plans by pursuing original and inventive member services and/or other additions to their benefit package.

All enhanced services must comply with the education/outreach and other relevant guidelines set forth in Section 4.0 of this Attachment, and must be approved by OMPP prior to initiating the service. Enhanced services may include, but are not limited to, such items as:

- Nurse triage telephone services for members to receive medical advice 24 hours-a-day/seven-days-a-week from trained medical professionals
- Coverage of some or all brand name drugs, even if they have a generic substitute
- Coverage of services provided by walk-in health clinics, such as the "Minute Clinic"
- Cost and quality information about providers, such as the appropriate service location for emergency vs. urgent care or the publication of hospital quality indicators. If information is provided about the quality of providers, the Plan must explain any limitations of the data.
- Disease management programs beyond those required by the State
- Intensive case management or care coordination for members with complex health care needs
- Group visits with nurse educators and other patients

2.10 Pharmacy Services

The Plan covers brand name and generic prescription drugs, and prescribed over-the-counter insulin. The following are exceptions to the coverage policy:

- Brand name and generic prescription drugs that are excluded from the Plan Description and Covered Benefits (as provided in Attachment E to the RFS).
- Brand name and generic prescription drugs that are classified as DESI according to the Centers for Medicare and Medicaid Services.
- Brand name drugs, where generic substitution is possible, in accordance with Indiana Pharmacy Law. Brand name drugs with generic substitutes are covered if the Plan deems the brand name drug to be medically necessary or the Plan determines that the brand name drug is less costly than the generic substitute.

If the insurer intends to impose coverage limitations on drugs, the insurer shall submit the proposed coverage limitations to the Office for review and approval at least thirty-five (35) days in advance of the proposed implementation date of the initial coverage limitations or subsequent changes. The Office shall determine submission format. Under no circumstances will the insurer be permitted to implement proposed coverage limitations without prior approval from the Office.

Subject to requirements set by the Office and in certain circumstances, as set by the Office, insurers may adopt coverage limitations for drugs. If an insurer seeks to adopt a limitation on one (1) or more drugs, the insurer shall implement an automated system for approval of a seventy-two (72) hour emergency supply of the drug.The automated system must allow the pharmacist to dispense the 72-hour supply and then follow-up with the Plan or provider the next business day.

Plans are expected to develop programs and policies that maximize the utilization of generic drugs where possible and clinically appropriate.

2.11 Cost-Sharing

With the exception of required POWER Account contributions (as described in Section 3.0 of this Attachment) and co-payments for emergency room services, the program does not allow cost-sharing. POWER Account contributions, as described below, will be administered in compliance with 42 CFR 447.50 and 447.53 through 447.60.

3.0 Personal Wellness & Responsibility (POWER) Accounts

The Plan must establish and administer a Personal Wellness & Responsibility (POWER) Account for each member. Members will use POWER Account funds to meet the deductible of their deductible health plan.

Members must make a financial contribution to their POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious and to utilize services in a cost-efficient manner as well as to seek price and quality transparency. Members must be aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower next year's contribution.

In administering member POWER Accounts, the Plan is welcome and encouraged to pursue innovative strategies or services beyond the minimum requirements set forth in this Section, so long as they reinforce personal responsibility, cost and quality transparency or preventative service use, or otherwise promote the goals of the Program. Such plans should be outlined in the response to this RFS and will be additional criteria of technical and qualitative assessment for all RFS respondents.

The Plan must engage an external entity to conduct an annual audit of its POWER Account management.

3.1 POWER Account Requirements

At minimum, POWER Accounts will be funded in an amount equal to each member's annual deductible, which is currently $1,100. Individual members, as well as the State, will contribute to the POWER Account. Employers are also invited to contribute to member POWER Accounts.

3.1.1 Individual Member Contributions

In order to participate in the Program, individuals will be required to help fund the $1,100 deductible by contributing to their POWER Account. Required contributions will be based on a sliding scale, will not exceed 2-5% of a participant's gross annual family income and will be reduced to account for any other payments being made to Medicaid, Hoosier Healthwise or Medicare.

The sliding scale for POWER Account contributions is as follows:

- For members with annual household income of 100% FPL or less, the POWER Account contribution shall not exceed 2% of the member's annual household income

- For members with annual household income above 100% FPL and not more than 125% FPL, the POWER Account contribution shall not exceed 3% of the member's annual household income

- For members with annual household income above 125% FPL and not more than 150% FPL, the POWER Account contribution shall not exceed 4% of the member's annual household income

- For *parents* with annual household income above 150% FPL and not more than 200% FPL, the POWER Account contribution shall not exceed 4.5% of their annual household income

- For *childless adults* with annual household income above 150% FPL and not more than 200% FPL, the POWER Account contribution shall not exceed 5% of their annual household income

The State will develop an algorithm to determine the amount of an individual's required contribution and will notify the Plan of this amount. The Plan must bill for, and collect, the required individual contribution. Members must be given the opportunity to pay their required contribution in equal monthly installments. The first installment will be due 60 days after an individual's "qualified enrollment" in the Plan (i.e., after the individual is determined to be eligible for the Program and assigned to a plan), and shall not exceed one-twelfth (1/12) of the individual's total required annual individual POWER Account contribution. Enrollment in the Plan will not be finalized, and coverage will not begin, until the 1st day of the coverage month after the payment is received, or, if payment is made by check, the check clears.

In families with two eligible adults, each member will have their own, individual POWER Account. However, the total of both eligible adults' POWER Account contributions cannot exceed the total POWER Account contribution that applies to the family's annual household income (see the sliding scale contribution limits outlined above). For example, the parents in a family of four (2 adults and 2 children) with annual income of $20,000 (100% of FPL) will each contribute $200 to their separate POWER Accounts during the coverage term, for a total family "contribution" of $400 ($20,000 x 2% = $400).

For ease of administration, if more than one family member is eligible for the Program, all eligible family members will be required to enroll in the same Plan. This allows the Plan to collect a single family contribution on behalf of all individuals eligible for the Program in the same family. The only exception to this rule will occur in families where one of the family members has a high-risk health condition(s) and is referred into the State's high-risk plan instead of a plan providing services under this RFS. In these cases, the family members will receive care from different plans: The family member with the high-risk health condition(s) will be enrolled in the State's high-risk plan, while the remaining family member(s) will enroll in a plan providing services under this RFS. Plans providing services under this RFS will still bill and collect the entire family contribution, but must keep a record of any portion of the family contribution that is attributable to a family member(s) enrolled in the State's high-risk plan. On a monthly basis, as determined by the State, the Plan must forward or credit any POWER Account contributions attributable to a family member(s) enrolled in the State's high-risk plan to the State or the State's contractor for the high-risk plan. Please see Attachment F, Responsibilities of the State, of this RFS for further information about the State's high-risk plan.

3.1.2 State Contributions

The State will fund any gap between a participant's required contribution (which will be capped at 2-5% of family income) and the $1,100 deductible. For example, if the participant's annual income is $9,800 (100% FPL), their required contribution will be $196 (2% of $9,800 = $196) and the State's contribution will be $904 ($1,100 - $196 = $904). The State will make its entire contribution to the POWER Account promptly after receiving notice from the Plan that the member's first POWER Account contribution has been received and processed.

3.1.3 Employer Contributions

Employers are permitted and encouraged to contribute to member POWER Accounts. The Plan must establish policies and procedures for marketing the Program to the employers of its members, and must establish a straightforward process to allow employers to contribute to employee POWER Accounts. The Plan's marketing materials for employers must set forth the process the employer can use to contribute to employee POWER Accounts.

As established in IC 12-15-44-10, an employer's contribution must be used to offset the employee's required contribution only—not the State's—and cannot exceed more than 50% of the employee's required contribution.

3.2 Use of POWER Account Funds

Each member will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the member to pay for the Plan's covered services, including any enhanced services the Plan may choose to offer. A list of the required covered services is provided in Attachment E of this RFS.

In spending POWER Account funds, members must be permitted to pay for the following covered services, even if obtained through out-of-network providers:

- Family planning services, if obtained from a IHCP provider
- Emergency medical services, subject to the prudent layperson standard of an "emergency medical condition," as specified in 42 CFR 438.114 and Section 2.2 of this Attachment
- Medically necessary covered services, if the Plan's network is unable to provide the service within a 60-mile radius of the member's residence, as specified in 42 CFR 438.206(b)(4) and Section 2.6 of this Attachment
- Nurse practitioner services, if provided by an IHCP provider

For the out-of-network services listed above, the Plan must coordinate with the out-of-network provider to ensure that the cost to the member is no greater than it would be if the services were provided in-network. If the out-of-network provider lacks the capacity to conduct the transaction using the member's "POWER Account card," the provider must be instructed to bill the Plan and the Plan must reimburse the out-of-network provider with funds in the member's POWER Account. See Section 3.3.2 of this Attachment for additional information about the POWER Account card.

3.2.1 Emergency Room Services

Members must be restricted from using POWER Account funds to pay for the emergency room services co-payment described in Section 2.2.3 of this Attachment.

3.3 POWER Account Administration

The Plan must administer a POWER Account for each member. If necessary, this may be accomplished by partnering with a separate entity. If the Plan partners with a separate entity, the Plan will be responsible for the entity's performance.

3.3.1 Billing and Collections

The State will use an algorithm to determine the amount of a member's required contribution and will notify the Plan of the required contribution amount. This will occur during the application process. Contributions will also be recalculated by the State before a new coverage term begins (during redetermination), in order to account for changes in the member's income. If some or all of a member's POWER Account balance is rolled over at the end of the coverage term (as described in Section 3.4 of this Attachment), the amount of the member's POWER Account contribution for the new coverage term must be reduced by the amount of the member's rolled-over account balance from the previous coverage term.

The State may establish additional parameters, by rule or program guidance that will trigger member contribution recalculations during the middle of a coverage term, such as a significant decrease in a member's income due to family size changes (death, divorce, birth, etc.). If so, the State will notify the Plan if a member's contribution is changed. The Plan must notify members of any circumstances in which they may request a POWER Account contribution recalculation mid-coverage term, and explain that the member will be responsible for notifying the State about changes in income. If a member's POWER Account contribution is recalculated, the Plan must notify the member of the recalculated amount within 30 days.

The Plan must bill for, and collect, the required member POWER Account contribution. The Plan must give members the choice of paying their required contribution in equal monthly installments. The first monthly installment will be due within 60 days of the individual's qualified enrollment in the Plan (i.e., after being determined eligible for the Program and assigned to a plan) and the Plan's invoice must not exceed one-twelfth (1/12) of the member's total required annual POWER Account contribution. Plans are encouraged to have a system in place for reminding members about required POWER Account contribution due dates, particularly the due date of the first monthly installment.

Employers must be encouraged to contribute to their employees' POWER Accounts, and the Plan must establish a process for collecting employer contributions. The Plan may limit its acceptance of employer contributions to one payment per year.

If applicable, families must be permitted to make combined payments on behalf of all members enrolled in the Program in the same family. For example, this situation will arise in a family with two adults enrolled in the Program. In cases like these, the Plan will be required to distribute the combined payment evenly between the POWER Accounts of each family member provided the member(s) submits the specific invoices with combined payment. And, as described in Section

3.1.1 of this Attachment, if at least one of the family members is enrolled in the State's high-risk plan instead of a plan providing services under this RFS, individuals will be required to submit payment separately to each plan.

The Plan must provide members with an automatic payroll deduction option for making individual contribution payments, in addition to accepting payment by mail. Pursuant to IC 12-15-44-10, the Plan must also establish a process for employer to forward to the Plan any employee withholding (after taxes). In the case of a member with multiple employers, the plan is only required to provide this option for one of the employers of the member. The Plan must also provide a mechanism that allows members to pay their POWER Account contribution in cash. The Plan may offer additional options for making the required contribution, including automatic withdrawal from the member's checking account, on-line bill pay or other options that make it easy for members to make the required contributions. Innovation by the Plan in assuring the collection of individual contributions is highly desired.

Coverage under the Plan will not begin, and a member's enrollment in the Plan will not be final, until the 1st day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears. The Plan must deposit checks no later than 15 calendar days from receipt. The Plan must promptly notify the State after a member's first POWER Account contribution installment has been processed, within 10 days. The State will provide its entire share of the POWER Account promptly after receiving notice from the Plan that the member's first POWER Account contribution has been processed.

The Plan must collect all refunds due to the State in a calendar month and submit these refunds as a credit to the State by the 15th day of the following month. All refunds are based on three reconciliation periods:

- Member: 60 calendar days from date of member termination
- State: 180 days from date of member termination
- Final: 570 days from date of member termination, only in instances where an appeal is associated with a claim

Such refunds will include, any credits due to the State after a POWER Account roll-over (as provided in Section 3.4 of this Attachment) or any credits due to the State after a POWER Account refund (as provided in Sections 3.3.1.1, 3.5 and 3.6 of this Attachment).

3.3.1.1 Non-Payment of Monthly Contribution

If a member does not make a required monthly contribution within 60 days of its due date, the member will be terminated from participation in the Program and enrollment in the Plan. Payment via a dishonored check due to non-sufficient funds (NSF) will be considered non-payment, and members who have made such a payment will be disenrolled from the Program if their monthly contribution is not received within 60 days of its original due date. Before disenrolling the member from the Plan for non-payment of the monthly contribution, the Plan must provide the member with written notice with appeal rights of his or her non-payment. The notice must be sent to the member on or before the 7th day of non-payment and must state that the member will be disenrolled

from the Plan and terminated from participation in the Program if payment is not received. The notice must explain that if the member is terminated from participation in the Program, the member will not be able to reapply to the Program for a period of at least 12 months.

When a member is disenrolled from the Plan for non-payment and terminated from participation in the Program, the member forfeits 25% of his or her pro rata share of any funds remaining in the member's POWER Account at the time of disenrollment to the State. This means that upon termination from the Program and the Plan, the Plan will be required to refund only a portion of the member's pro rata share of the POWER Account. This refund shall be distributed to the member not later than 60 days after the date of member termination from the Plan. The amount payable to the member shall be determined as follows:

- Step One: Determine the paid into the POWER Account to date by the individual and the individual's employer (if any)
- Step Two: Determine the total amount paid into the individual's POWER Account from all sources
- Step Three: Divide the amount determined in Step One by the amount determined in Step Two
- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account
- Step Five: Multiply the amount determined under Step Four by seventy-five hundredths (.75 or 75%)

If a member is disenrolled from the Plan for non-payment, the Plan must disable the member's POWER Account card immediately. See Section 3.3.2 of this Attachment for additional information about the POWER Account card.

Within five (5) days of disenrolling a member from the Plan, the Plan must notify the State of the member's disenrollment, as well as the cause for the disenrollment. Any funds that remain in the POWER Account must be credited to the State as provided in Section 3.3.1 above.

3.3.1.2 Member Pregnancy

As outlined in Section 2.4.1 of this Attachment, when a member becomes pregnant, she will be disenrolled from the Program and the Plan and will be enrolled in Hoosier Healthwise instead. Upon her disenrollment, the Plan must return her pro rata share of any POWER Account balance in accordance with Section 3.3.1 within 60 days of her last date of participation with the Plan, in accordance with Section 3.5 below. The remaining balance must be credited back to the State, in accordance with Section 3.3.1 above.

3.3.2 The POWER Account Card

The Plan must issue a POWER Account/membership card to each member promptly after processing the member's first POWER Account contribution, within 5 days. The POWER Account/membership card will provide members with electronic access to their POWER Account funds. Each time a contribution to the member's POWER Account is made, the Plan must credit the member's POWER Account/membership card accordingly. The plan may send regular e-mail communications to the member to direct the member to a secure web site to view member account balance information and age and gender-specific recommended preventative care. Account balance information and other information such as preventive care guidelines and protected health information will not be included in the e-mail communication.

The Plan must ensure that each POWER Account/membership card is used by members only to pay for covered services actually performed by approved providers. This may require use of EBT-type card readers at contracted, in-network provider offices, eliminating a member's ability to use the POWER Account/membership card for a non-covered service.

For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the member's POWER Account/membership card, the Plan must instruct the provider to bill the Plan and the Plan must reimburse the out-of-network provider with funds in the member's POWER Account.

3.3.2.1 Replacement POWER Account Cards

The Plan must make replacement POWER Account cards available to members who lose or destroy their original POWER Account card. The first replacement POWER Account card will be issued at no cost to the member. The Plan may charge a reasonable fee for each additional replacement POWER Account card.

3.3.3 POWER Account Balance Information

The plan may send monthly e-mail communications to the member to direct the member to a secure web site to view member account balance information, or the plan can make POWER Account balance information available in the form of an electronic account update that will be e-mailed to members on a monthly basis and as changes occur. Members will be directed to a secure web site to review other information, such as age and sex appropriate preventative service and utilization reminders, in the monthly account updates. Up-to-date account balance information must also be available to members online and by contacting the Plan's Member Helpline.

EOB statements must be available to members electronically, via a secure web site. The electronic EOB statement or member health statement must reflect the change in the member's POWER Account balance including benefit balance and funding balance. The year-to-date usage amount must be included on each EOB statement.
If possible, POWER Account balance information should also be available in the form of a receipt at service locations where the POWER Account card is used, if the plan implements a pre-paid debit card.

3.3.4 Interest

Members will not earn interest on their POWER Accounts.

3.4 Roll Over and Use of Excess Funds

At the end of a 12-month coverage term, there may be funds remaining in a member's POWER Account. In this situation, the Plan must follow the procedures outlined below.

3.4.1 Roll Over

At the end of a coverage term, some or all of the funds remaining in a member's POWER Account must be rolled-over into the next coverage term for purposes of reducing the member's required POWER Account contribution in the upcoming year. The amount of leftover funds available for roll-over will depend on the member's utilization of recommended preventative care services. Each coverage term, OMPP will determine which recommended preventative care services apply to a specific member's age and gender, as well as the member's pre-existing conditions. Members that obtain all recommended preventative care services will be able to roll-over their entire POWER Account balance, including monies contributed by the State. During the first year of the Program, the completion of an annual check-up at a physician's office will be considered sufficient preventative care for the purposes of full POWER Account fund roll-over. The Plan will make member funds available within 60 days and State funds available within 180 days. Members that fail to obtain the recommended preventative care services may only roll-over their pro-rata share of the POWER Account balance, leaving less money available to reduce the next year's required contribution. Consider the following example:

- A member contributes $400 to the POWER Account over the course of a coverage term and the State contributes $700, for a combined contribution of $1100 ($400 + $700 = $1100).

- The member spends $450 of POWER Account funds to pay for covered services under the Program during the coverage term. At the end of the coverage term, $650 remains in the member's POWER Account ($1100 - $450 = $650).

- ***If the member obtained the preventative care services*** recommended by OMPP for his or her age, gender and pre-existing conditions before the end of the coverage term, the entire $650 POWER Account balance will be rolled-over and used to reduce the member's required POWER Account contribution in the upcoming coverage term.

- ***If the member did not obtain the preventative care services*** recommended by OMPP for his or her age, gender and pre-existing conditions before the end of the coverage term, only the member's pro rata share of the remaining account balance will be rolled-over. In this case, the member's pro rata share would be $234 (4/11 or .36 x $650 = $234). $234 will be rolled-over and used to reduce the member's required POWER Account contribution in the upcoming coverage term. The Plan must credit the remaining balance of $416 ($650 – $234 = $416) to the State.

- If the roll-over amount calculated on behalf of the member is in excess of the member's required POWER Account contribution for the next coverage term, the excess amount will be credited to the State to reduce the State's contribution in the next coverage term. This shall occur regardless of whether or not the member obtained his or her recommended preventative care services.

POWER Accounts are designed to encourage preventative care, the appropriate utilization of health care services and personal responsibility. Plans must emphasize to their members that responsible use of POWER Account funds, as well as utilization of recommended preventative care services, can lead to a reduced financial burden in the upcoming year. If members are aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower their next year's contribution—members will be encouraged to make value- and cost-conscious decisions.

3.4.1.1 State Notice

The Plan must have mechanisms in place to monitor when a member has obtained all the preventative care services recommended for his or her age and gender, as well as pre-existing conditions, in a coverage term. On an annual basis, the Plan must provide preventative services compliance reports to the State. During the first year of the program, an annual physical will be considered preventative services compliance. The format of these reports are under development at this time, but will be expected to include a summary of member compliance and non-compliance with OMPP recommended preventative services.

Following the conclusion of a coverage term, the Plan must also notify the State of the amount, if any, of the member's POWER Account that will be rolled-over to reduce the next coverage term's required contribution. This notice must also indicate the amount, if any, of the member's POWER Account that will be credited back to the State due to the member's failure to obtain recommended preventative care services (i.e., the State's pro rata share). These funds must be credited back to the State as a refund as provided in Section 3.3.1 above. If the Plan receives claims for preventative care services after the member's account has been rolled over and amounts are credited back to the State, the Plan will not be at risk for any overpayments made to the State and the appropriate readjustments will be made.

3.4.2 Recalculation of Member Contributions

Recertification of eligibility in the Program will occur every 12 months and will be based on criteria set forth by the State. If a member is determined to remain eligible for the Program at the end of a coverage term, the member's POWER Account contribution will need to be recalculated for the new coverage term. The State will recalculate the member's POWER Account contribution based on any changes in the member's income recognized during redetermination.

The State will notify the Plan of the member's POWER Account contribution for the new coverage term. Promptly thereafter, within 60 days, the Plan must: 1) reduce the member's POWER Account contribution for the new coverage term by the amount of the member's POWER Account balance that was rolled-over pursuant to Section 3.4.1 of this Attachment (if

any); and 2) notify the member of this roll-over amount, as well as the new amount to be billed to the member in equal monthly installments in the new coverage term.

Due to the fact that the first POWER Account installment in the new coverage term may become due before the member's individual contribution has been recalculated by the State, the member may be billed by the Plan according to the prior year's required contribution schedule. However, the Plan will be required to reconcile any overpayments or underpayments made by the member within 60 days of being notified by the State of the member's recalculated contribution amount for the new coverage term.

3.4.3 POWER Account Balance Transfers

If a member disenrolls from the Plan and transfers into a new plan, including the State's high-risk plan, the Plan must promptly transfer the member's POWER Account balance to the State within 30 days of notification by the fiscal agent. The plan will not be responsible for any claims for services provided after the transfer.

If a member disenrolls from the Plan at the end of a 12-month coverage term and transfers into a new plan, as permitted in Section 4.1.5 of this Attachment, or is referred to the State's high-risk plan by the State at the end of the coverage term, the Plan remains responsible for determining the amount of the member's permitted roll-over balance, as well as any amounts that must be credited back to the State. The Plan will be required to forward the roll over amount to the State and credit to the State its share of account balance in accordance with Section 3.3.1, if applicable.

A member may change plans during the 12-month coverage period with cause (defined by the State as poor quality health care coverage). If a plan change for cause is approved by the State, the Plan must notify the fiscal agent of the remaining balance of the POWER account (member and State contribution amounts) as of the effective date of the approved plan change. The POWER account remaining balance will be moved (through fiscal agent) from the current Plan to the new Plan without regard to the point of time during the 12-month coverage period. The movement of POWER account dollars between insurers must be done through fiscal agent so that the Financial Department of FSSA can track the monies appropriately. This includes all receivables, outgoing payments and recoupments.

3.5 Loss of Eligibility

If member becomes ineligible for the Program, either during redetermination at the end of a coverage term or at another time, the Plan must refund the member's pro rata share of his or her POWER Account balance, if any, within 60 days of the member's date of termination from the Plan. If a Plan sends a POWER Account refund check to a member and the check is returned to the Plan because the member cannot be located, the Plan should handle the member's unclaimed refund pursuant to Indiana Statute (IC 32-34-1, et seq.). The amount payable to the member shall be determined as follows:

- Step One: Determine the amount paid into the POWER Account to date by the individual and the individual's employer (if any)
- Step Two: Determine the total amount paid into the individual's POWER Account from all sources

- Step Three: Divide the amount determined in Step One by the amount determined in Step Two

- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account

Any funds remaining in the POWER Account after the member rebate must be credited to the State according to Section 3.3.1 above. The Plan will have 180 days from the member's date of termination from the plan to credit the State.

Upon completion of the reconciliation of the POWER account, Plan must notify the fiscal agent of the amount of the refund paid to the member, even if the amount is zero, in order to verify to State that the reconciliation process is finalized. This reconciliation will take place within 180 days. The Plan can make adjustments up to 570 days after member termination based on appeals made by providers and members that result in adjustments.

If a claim comes in after the account has been reconciled and refunded, the Plan will determine if there are dollars owed by the State (through fiscal agent) (in the event that the deductible has not been met) and the member based on the same percentages used to create and administer the member's POWER account.

For any claim paid after the account has been reconciled and refunded, the Plan must:

- Notify fiscal agent of the State portion due. Fiscal agent will pay this amount using the existing POWER account HIPAA 820 process (notification) and EFT process (payment).
- Notify fiscal agent of the member portion due. Fiscal agent will record the member's debt in system and attach it to the member and the Plan for the timeframe of the debt.

The Plan may bill the member directly for the member portion due and will register with the Plan any member debts per section 3.8. The Plan must notify fiscal agent once the debt has been resolved (paid by the member). The Plan *cannot* sell off the member debt to a collections agency.

3.6 Failure to Renew Participation in the Program

If a member fails to complete all necessary steps to maintain or renew eligibility in the Program during redetermination, the State is responsible for ensuring that the member will not be permitted to reapply for the Program for a period of at least 12 months. The Plan will be required to refund the member's pro rata share of his or her POWER Account balance, if any, within 60 days of the date of member termination from the Plan. The amount payable to the member shall be determined according to the process set forth in Section 3.5 above. Any other funds remaining in the POWER Account must be credited to the State according to Section 3.3.1 above.

3.7 Provider Reimbursement

Participating providers will be reimbursed at Program rates (i.e., Medicare rates) when a member purchases covered services under the Program with POWER Account funds. In most cases, there will be sufficient funds in the member's POWER Account and the member will use his or her POWER Account card to reimburse the provider electronically and without cash at the point of service. In some cases however, the cost of the covered service may exceed the member's current POWER Account balance,

even though the State will be making its entire POWER Account contribution at the beginning of the coverage term. For example, early in the coverage term the member will have only made a few contributions to the POWER Account. In this case, the member will use his or her POWER Account card to pay for the portion of the bill that his or her POWER Account funds can cover. The provider must be permitted to bill the Plan for the remaining balance, and the Plan must reimburse the provider for the balance according to its normal claims processing procedures. The Plan can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

As indicated in Section 8.8 of this Attachment, the Plan will be required to report to OMPP on a monthly basis the number and average amounts of payments made by the Plan to providers due to an insufficient funding of the member's POWER Account at the time of service.

If a member obtains covered services from an out-of-network provider that lacks the capacity to conduct a transaction with the member's POWER Account card, the out-of-network provider must be allowed to bill the Plan, and the Plan must reimburse the out-of-network provider with funds in the member's POWER Account.

3.7.1 Access to the Plan's Provider Reimbursement Rates

The Plan must ensure that its members have access to its negotiated provider reimbursement rates under the Program (i.e., Medicare rates) when they are purchasing covered services with POWER Account funds. This means that providers providing covered services under the Program cannot charge the member an amount that exceeds the established Program rate (i.e., Medicare rates) for the covered service.

3.8 POWER Account Debt Collection Process

The fiscal agent's system, will document member debt owed and the Plan to whom the debt is owed.

- The Plan will continue to pursue a member's debt during the member's penalty period following non-payment and after.
    a. The Plan may pursue collection of member debt from previously terminated Plan members in accordance with standard company practice for collection of debt in the individual market segment. The Plan must not sell the member's debt.
- When the debt is resolved (paid by the member), the Plan must notify the fiscal agent so that the debt in the system can be end dated.

Once the member's 12 month penalty period is up, he/she can re-apply for HIP. The application process will remain the same with the following differences:

1. If the enrollment broker (EB) is contacted for choice counseling, the EB will be trained to look for outstanding debt and notify the member that the debt must be cleared before the new HIP eligibility can begin.
2. When fiscal agent receives the member's conditional approval notification from ICES, the member's data is sent to the new Plan (this can be the previous Plan or a new one). The data sent will include the POWER account information plus the amount of debt owed and corresponding debt documentation. All of which must be paid by the member before the new HIP eligibility can begin.

Situation	Action
If the member's new plan is debt plan	No action necessary
If the member's new plan is not debt	Once the fiscal agent receives notice from ICES that

plan	HIP eligibility is open (member has paid debt in full), the fiscal agent will: 1. End-date debt 2. Recoup debt amount from new plan 3. Pay debt amount to debt plan
If the member doesn't pay debt	Debt remains attached to member until member pays. HIP eligibility will not start until member pays. Fiscal agent will not pay HIP capitation until member pays.

4.0 Member Services

4.1 Member Eligibility and Enrollment

Individuals will only be able to apply for the Program through traditional venues, including the Division of Family Resources (DFR) and other authorized enrollment locations (such as hospitals and health clinics). The Plan will be expected to conduct marketing and outreach efforts to raise awareness of both the Program and their product. Plans must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. Plans must provide information to potential eligible individuals who live in medically underserved rural areas of the State. As described in Section 4.2 of this Attachment, Plan marketing and outreach materials must be approved by OMPP.

The State is currently in the process of outsourcing its front-end application processing functions for FSSA programs. The new application system will be rolled-out on a regional basis, and the goal is that this system will be fully operational by mid-2008. With the new system, individuals will be able to apply for the Program and other FSSA programs using a web-based application or Call-In Center, or by faxing or mailing the application to a central Document Center.

Because the new application system is still in the implementation phase at the time of issuing this RFS, Sections 4.1.1 and 4.1.2 below should be considered goals and may be subject to change by the State.

4.1.1 Application through the Division of Family Resources (DFR)

As stated above, the State has undertaken a large eligibility modernization project to improve customer service, accuracy and access and to make better use of technology. When this project is completed, individuals will be able to apply for the Program online, over the phone, by mail or, as a last resort, in person.

Enrollment through DFR shall occur as follows:

- If an individual indicates they are interested in applying for the Program, DFR will explain the Program to the individual, and if the individual wishes to apply for the Program, proceed with the application and enrollment process. Individuals will also be able to apply for the Program online, over the phone and by mail.

- Through an automated process, the applicant's application form will be checked for completeness. If the application is not complete, DFR will contact the applicant about obtaining missing information.

- The applicant will be asked to sign the application. Electronic signature capabilities are likely. The applicant will also be asked to provide the necessary supporting documentation and verifications for application in the Program. The following are examples of necessary supporting documentation or verification:

    - Proof of citizenship, such as a birth certificate and picture ID
    - Proof of residency
    - Proof of income, such as pay stubs

- As part of the application process, the applicant must complete a high-risk health questionnaire. If the applicant's answers on the high-risk health questionnaire indicate that a high-risk condition may be present, OMPP will review the applicant's case for potential referral into the State's high-risk plan (assuming the applicant is determined to be eligible for the Program). Please see Attachment F to this RFS for further information about referral into the State's high-risk plan.

- After obtaining a completed application, DFR will refer applicants to the State's enrollment broker for assistance in selecting a Plan. The enrollment broker will provide the same services it provides for Hoosier Healthwise—including the provision of information about available plans—to applicants in the Program. If an applicant fails to make a plan selection, the applicant will be auto-assigned to a Plan. For ease of administration, if more than one family member is eligible for the Program, all eligible family members will be required to enroll in the same Plan. However, if a family member is transferred into the State's high-risk plan, this rule does not apply. Only the family member determined to be high-risk will enroll in the State's high-risk plan. Other family members eligible in the Program will be enrolled in a participating Plan.

- DFR will make its final eligibility determination within 45 days of receiving application materials and will forward its determination to the applicant. If eligible, the individual's required POWER Account contribution amount will also be calculated in this timeframe. DFR's notification to the applicant will include information about their required annual POWER Account contribution.

- Individuals eligible for the Program are deemed "conditionally eligible." Eligibility does not become final until the individual has paid their first POWER Account contribution to the Plan.

4.1.2 Application through Designated Enrollment Centers

Individuals may also apply for the Program through designated enrollment centers (such as hospitals, schools, community organizations, health clinics, etc.). There are currently 349 designated enrollment centers throughout the State. Pursuant to a formal agreement with the State, the enrollments centers will assist individuals with the application process described in Section 4.1.1 above. The enrollment center shall then forward the applicant's completed application, including supporting documentation, to DFR online or via U.S. mail. DFR will refer

the applicant to the enrollment broker to make a plan selection after obtaining the applicant's application materials. DFR will make a final eligibility determination within the 45-day period proscribed by CMS. This period begins once the enrollment center has received a signed application.

4.1.3 Member Enrollment in Plans

Plans must not discriminate against individuals eligible to enroll on the basis of health status or need for health services, with the exception of permitted referrals by the State to the State's high-risk plan, which specializes in managing the care of high-risk populations. Please see Attachment F, Responsibilities of the State, for more information about referral to the State's high-risk plan. Additionally, Plans must not discriminate against individuals eligible to enroll on the basis of race, color, national origin, ancestry, disability, age, sex or religion and must not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, disability, age, sex or religion.

All applicants determined to have a high-risk health condition will not have a choice between the plans providing services under this RFS and will be enrolled in the State's high-risk plan instead.

Plans must accept individuals eligible for enrollment in the Plan in the order in which they apply without restriction. Plans must accept as enrolled all individuals appearing on the enrollment rosters whose enrollment is deemed "final" or enrollees for whom the Plan receives capitation payment and/or a POWER Account contribution. The Plan will be responsible for reconciling the member enrollment roster and capitation payment and POWER Account contribution file on a monthly basis.

Promptly after receiving notice of an individual's qualified enrollment in the Plan (i.e., after the individual is determined to be eligible for the Program and assigned to the Plan), the Plan must notify the applicant. This notice must explain that if the individual does not submit the first installment of their POWER Account contribution within the specified time frame (i.e., 60 days after qualified enrollment in the Plan), their coverage under the Plan will not commence and the applicant will be prohibited from participating in the Program for a period of at least 12 months. The notice should include a copy of the Plan policy. The welcome letter the Plan sends to applicants deemed conditionally eligible must have a notice prominently displayed on the first page stating in substance that the member has the right to join another plan before the first POWER Account contribution is made.

After the individual's enrollment is deemed final (i.e., after the first POWER Account contribution is made), the Plan must provide a member handbook, POWER Account information, information about the recommended preventative services that apply to the member's age, gender and pre-existing conditions and a member identification card, which may also serve as the member's POWER Account card (as described in Section 3.3.2 of this Attachment). OMPP will establish guidelines pertaining to the standard information, which must be included on the member identification card. Further information about member enrollment materials is set forth in Section 4.2.2 of this Attachment.

If a Plan receives enrollment information for a member, the Plan is financially responsible for the member the 1st day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears. The State will provide

its entire share of the member's POWER Account and start making capitation payments after receiving notification that the member's first POWER Account contribution has been made.

4.1.4 Eligibility Recertification in the Program

Recertification of eligibility in the Program will occur every 12 months and will be based on criteria set forth by the State. Plans will be required to assist members in initiating/completing the recertification process, and may begin as early as 60 days prior to the end of the coverage term and in compliance with FSSA processing guidelines. These steps will help prevent interruptions in member care or access to health services.

If a member can prove that they initiated the recertification process through the Plan, the Plan will have to continue covering the member after the end of the coverage term if the Plan failed to submit the materials to the State or otherwise assist the member in completing the recertification process.

In addition, liquidated damages of $1,000 will be assessed for each instance in which a member can prove that the Plan failed to submit the member's recertification materials to the State or otherwise failed to assist the member in completing the recertification process.

4.1.5 Member Disenrollment From Plan

In accordance with 42 CFR 438.6(d), the Plan may neither terminate enrollment nor encourage an enrollee to disenroll because of a member's health care needs or a change in a member's health care status, and a member's health care utilization patterns may not serve as the basis for disenrollment from the Plan. However, these prohibitions should not be interpreted to preclude permitted referrals by the State to the State's high-risk plan. Please see Attachment F of this RFS for further information about the State's high-risk plan. In addition, these prohibitions should not be interpreted to preclude disenrollment from the Plan when required due to a member's pregnancy and subsequent enrollment in Hoosier Healthwise.

Members will have a right to change plans before their first POWER Account contribution is made. Additionally, at the end of each 12-month coverage term, members will have an opportunity to transfer into another plan pursuant to 42 CFR 438.56. The Plan will be required to provide 60 days notice to members about their right to change plans at the end of a coverage term.

The Plan must notify the member when he or she approaches the annual and lifetime coverage limits. When the member has utilized $100,000 and $200,000 of coverage within an annual coverage period or $900,000 of lifetime coverage, the Plan must inform the member and provide relevant information regarding ongoing coverage sources such as ICHIA, M.E.D. Works, and Medicaid. The plan will send separate notices for the $100,000 level, the $200,000 level and the $900,000 level. When the member has reached the annual and lifetime coverage limits, the Plan must inform the member and again provide relevant information regarding ongoing coverage sources. The Plan must notify the State when a member reaches their lifetime coverage limit. If the member has reached just the annual limit, they must still make their POWER account contributions in order to remain eligible in the following year, although no services will be covered in the current term. In the case of the lifetime member, the member will be disenrolled from the program permanently.

The Plan must notify DFR within 30 calendar days of the date it becomes aware of the death of one of its enrollees in the Program, giving the enrollee's full name, address, Social Security Number, member identification number and date of death. The Plan will have no authority to pursue recovery against the estate of a deceased enrollee in the Program. A deceased member's estate will have a right to the member's pro rata share of his or her POWER Account funds. Coverage under the Program will end effective the date of the member's death.

If a member is disenrolled from the Plan, the Plan must disable the member's POWER Account card immediately, if applicable. A deceased member's POWER Account will be reconciled according Section 3.3.1. The State will recoup any capitation payments made to the Plan following a member's death.

Additional information about member disenrollment is provided in Attachment F of this RFS.

4.2 Member Outreach, Marketing and Education

4.2.1 Marketing and Outreach

The Program represents a public-private partnership between the State and participating plans for expanding coverage to uninsured Hoosiers, and OMPP expects the Plan to promote both the Program and their product and services to the general community. In accordance with 42 CFR 438.104, however, the Plan cannot conduct, directly or indirectly, door-to-door, telephone or other "cold-call" marketing enrollment practices. Additionally, the Plan must not distribute any marketing materials without first obtaining OMPP approval.

The Plan may market by mail, mass media advertising (e.g., radio and television) and community-oriented marketing directed at potential members. Plans must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. Plans must provide information to potential eligible individuals who live in medically underserved rural areas of the State. Marketing materials should include the requirements and benefits of the Plan, as well as the Plan's provider network.

The Plan may offer gifts, incentives, or other financial or non-financial inducements, so long as the Plan acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other Federal and State regulations and guidance regarding inducements in the Medicare and Medicaid programs.

The Plan must submit to OMPP a marketing and member materials distribution plan quarterly. All member outreach, marketing and education materials, as well as any form letters that are sent to members (e.g., notification or welcome letters, annual notices, etc.) must be submitted to OMPP for approval prior to distribution and in accordance with OMPP policy. In addition, the Plan must notify OMPP of any changes to the work plan that occur throughout the year. Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, at a fifth grade reading level, and must not be misleading or designed to confuse or defraud members and/or potential members. Examples of false or misleading statements include, but are not limited to:

- Any assertion or statement that the member or potential member must enroll in the Plan to obtain benefits or to avoid losing benefits

- Any assertion or statement that the Plan is endorsed by CMS, the Federal or State government, or a similar entity

- Any assertion or statement that the Plan is the only opportunity to obtain benefits under the Program

The Plan cannot entice a potential member to join the Plan by offering the sale of any other type of insurance as a bonus for enrollment, and the Plan must ensure that a potential member can make his/her own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a distribution of potential members across age and sex categories. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with State or Federal law.

The Plan may distribute or mail an informational brochure or flyer to potential enrollees and/or provide (at its own cost, including any costs related to mailing) such brochures or flyers to the State for distribution to individuals that apply for the Program through the State. The Plan may submit promotional poster-sized wall graphics to OMPP for approval.

If approved, the Plan can make these posters available to the local DFR offices and other enrollment centers for display in an area where Program application and/or Plan selection occurs. The local DFR offices and enrollment centers may display these promotional materials at its discretion. The Plan may display these same promotional materials at community health fairs or other outreach locations. OMPP must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

If the Plan desires to use the Program logo created by the State, the Plan must request approval from OMPP for each desired use. Any approval given for logo use is specific to the use requested, and shall not be interpreted as a blanket approval.

4.2.2 Member Information and Education Programs

The Plan must provide the information listed under this section following the member's enrollment in the Plan, within a reasonable timeframe to be determined by the State. In addition, the Plan must notify members at least once a year of their right to request and obtain the information listed in this section. OMPP must approve the Plan's member notification letter. If the Plan makes significant changes to the information provided under this section, the Plan must notify the member in writing of the intended change at least 30 calendar days prior to the intended effective date of the change, in accordance with 42 CFR 438.10(f)(4). (OMPP defines "significant" changes as any changes that may affect member accessibility to the Plan's services and benefits.)

After an individual's enrollment in the Plan becomes final, the Plan must promptly, in a timeframe to be determined by the State, provide to the member a member handbook, POWER Account information, information about the recommended preventative services that apply to the member's age, gender and pre-existing conditions, a copy of the Plan policy and a member identification card, which may also serve as the member's POWER Account card (as described in

Section 3.3.2 of this Attachment). OMPP will establish guidelines pertaining to the standard information which must be included on the member identification card.

The Plan must make written information available in English and Spanish and other prevalent non-English languages identified by OMPP, upon the member's request. In addition, the Plan must identify additional languages that are prevalent among the Plan's membership.

The Plan must inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as Braille, large font letters, audiotape, prevalent languages, and verbal explanation of written materials. Written materials must not exceed a fifth grade reading level.

The Plan must provide notification to OMPP and to its members of any covered services under the Program that the Plan or its sub-contractors or networks do not elect to cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102. This information must be relayed to the member before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service.

Written information on the Plan's advance directives policies, including a description of applicable State law, must be provided to members in accordance with 42 CFR 438.10(g)(2).

Grievance, appeal and fair hearing procedures and timeframes must be provided to members in accordance with 42 CFR 438.10(g)(1). Please see Section 4.6 below for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the Plan must provide to members.

In accordance with 42 CFR 438.10(g)(3), the Plan must inform its members that, upon the member's request, the Plan will provide information on the structure and operation of the Plan, as well as information on the Plan's provider incentive plans (if any).

The Plan will be responsible for developing and maintaining member education programs designed to provide the members with clear, concise, and accurate information about the Plan's policy and programs, the Plan's network, and the Program (including POWER Accounts, POWER Account cards, compliance with recommended preventative service guidelines and POWER Account roll-over). The State encourages the Plan to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Plan to develop community partnerships with these types of organizations to promote health and wellness within its membership.

The Plan's educational activities and services should also address the special needs of specific subpopulations, particularly women of child-bearing age who need to understand that they will not receive pregnancy-related services under the Program and will need to enroll in Hoosier Healthwise instead, as well as the needs of its general membership. The Plan must be prepared to demonstrate how these educational interventions reduce barriers to health care and improve health outcomes for members.

The Plan must have in place policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Plan must develop and include a Plan-designated inventory

control number on all member marketing, education, training or outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate OMPP's review and approval of member materials and document its receipt and approval of original and revised documents. The Plan's member handbook must also be submitted annually for OMPP's review, and 30 days before making a material change. OMPP reserves the right to approve all material changes prior to their release.

The Plan must produce and distribute member education materials approved by OMPP. The Plan must provide information requested by the State, or the State's designee, for use in member education and enrollment, upon request. Education materials must include, but are not limited to, the following:

- A detailed member handbook that includes the Plan's contact information and Internet website address and describes the terms and nature of services offered by the Plan, including the following information required under 42 CFR 438.10(f)(6):
    - The procedures for obtaining benefits, including authorization requirements
    - Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits from out-of-network providers
    - The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f)(6)(viii)
    - The post-stabilization care services rules set forth in 42 CFR 422.113(c)
    - Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any
    - How women will be disenrolled from the Program and will be enrolled in Hoosier Healthwise instead if they become pregnant
    - Applicable co-payments for emergency room services
- A provider directory listing the Plan's providers in its network and identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information in accordance with 42 CFR 438.10(f)(6)(i)
- Member rights and protections, as enumerated in 42 CFR 438.100. See Section 4.5 of this Attachment for further detail regarding member rights and protections.
- Ability to change plans at the end of a coverage term
- Plan telephone system scripts and "commercials-on-hold"
- Plan-distributed literature regarding all health or wellness promotion programs that are offered by the Plan
- Plan's marketing brochures and posters

- Notification letters to members regarding Plan decisions to terminate, suspend or reduce previously authorized covered services under the Program
- POWER Account education materials, as described in Section 4.2.2.2 below
- Information about the recommended preventative services for the member's age, gender and pre-existing conditions

The Plan must also provide information to members through an Internet website in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines that is available to members, providers and the community within six months of the effective date of the Plan's contract with the State. OMPP must pre-approve the Plan's website information and graphic presentations. The website information must be accurate and current, culturally appropriate, written for understanding at a fifth grade reading level and available in English and Spanish. The Plan must inform members that information on the website is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Plan must date each web page, change the date with each revision and allow users print access to the information. Such website information should include, but is not limited to, the following:

- The Plan's provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information as required in the Provider Directory. The Plan must update the on-line provider network information monthly at a minimum.
- The Plan's contact information for member inquiries, member grievances and appeals
- General information about POWER Accounts and confidential POWER Account balance information for individual members
- The Plan's drug formulary
- Access to a confidential, electronic Explanation of Benefits statement
- An interactive tool that provides members with information about the recommended preventative services for their age and gender
- The Plan is encouraged, but not required, to have price and quality information on covered services available to its members to on its member website.
- The Plan's member services phone number, TDD number, hours of operation and after-hours access numbers
- The Plan's wellness and prevention programs (if these are enhanced beyond standard coverage under the Program)
- A description of the Plan's disease management programs

- The member's rights and responsibilities, as enumerated in 42 CFR 438.100. Please see Section 4.5 of this Attachment for further details regarding member rights and responsibilities.
- The member handbook information
- The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
- In-network pharmacy locations
- A list and brief description of each of the Plan's member outreach and education materials, as well as a link to an electronic copy of each
- The executive summary of the Plan's Annual Quality Management and Improvement Program Plan Summary Report

The Plan must submit all marketing, educational, training and outreach materials to OMPP for review and approval at least 30 calendar days prior to expected use and distribution. Material changes to approved marketing, educational, training and outreach materials must also be submitted to OMPP for review and approval at least 30 calendar days before making the proposed change. The Plan must receive approval from OMPP prior to distribution or use of materials. OMPP will assess liquidated damages and impose other authorized remedies for the Plan's non-compliance in the use or distribution of any non-approved member materials.

4.2.2.1 Preventative Services Education and Outreach

The Plan must develop education and outreach plans that teach members about the importance of preventative care. These plans must include methods that encourage members to obtain the OMPP-recommended preventative services for their age, gender and pre-existing conditions, including member reminders and an explanation of the member's ability to roll-over additional account funds if recommended preventative services are obtained.

Plans are strongly encouraged to develop additional incentives and educational tools to increase member compliance with preventative care guidelines and promote healthy lifestyles among their membership, with particular attention paid to smoking cessation strategies. In addition, Plans should develop an interactive tool on the Plan's website that provides members with information about the recommended preventative services for their age, gender and pre-existing conditions.

4.2.2.2 POWER Account Education

In educating members about POWER Accounts, the Plan should emphasize those features of POWER Accounts that help members stay healthy, be value- and cost-conscious and utilize services in a cost-efficient manner. The Plan should educate members about the impact their health seeking behavior will have on their ability to use a left over POWER Account balance to reduce the next coverage term's required POWER Account contribution, as well as their right to obtain a partial rebate of POWER Account

funds after their participation in the Program concludes. Plans should emphasize the member's role in obtaining information about the value (both cost and quality) of health care services, and provide tools to help members obtain cost information.

The Plan must make sure member education materials provide detailed, understandable information about member POWER Accounts. Materials should be provided in an easy-to-understand format, at a fifth grade reading level, and must be approved by OMPP prior to distribution. Information must include, at a minimum:

- An explanation of the required member contribution and payment, as well as the potential source of other account contributions, such as employer contributions
- Covered services and prescription drugs
- Using the POWER Account card for covered services only
- What happens in the event an out-of-network provider lacks the ability to use the member's POWER Account card for payment (i.e., the provider will be able to bill the Plan)
- Contribution payment policies, including the member's right to make a payment up to 60 days after the monthly POWER Account contribution due date without losing eligibility in the Program
- Account balance refund policies, including the penalty for non-payment of monthly POWER Account contributions (i.e., forfeiture of 25% of member's pro rata share of the POWER Account balance and inability to reapply for the Program for a period of at least 12 months) and what happens in the event of a member's death
- How to pursue POWER Account contribution adjustments through DFR in the event of a change in income (should the State decide to establish a mid-coverage term recalculation process)
- Recommended preventative service use, roll over, reducing the next coverage term's required contribution and rebate
- Confidential electronic EOB statements

In particular, the penalty for non-payment of monthly contributions should be displayed prominently in the education materials. Information about roll over funds at the end of a coverage term should also be displayed prominently. Members should understand the incentives available for responsible use of POWER Account funds and receipt of preventative services. The Plan must explain that remaining account balances can be used to reduce the member's contribution in the next coverage term. Reminders regarding a member's compliance with recommended preventative care guidelines are required.

4.2.3 Cost and Quality Information

Due to the Program's POWER Account design, members have an incentive to obtain the best possible pricing. Plans are encouraged to make cost and quality information available to members in order to facilitate more responsible use of health care services and informed decision-making. Plans must devise inventive strategies to make members aware of the cost of health care services, with the goal being that members will act as partners with providers and the Plan to make responsible decisions about appropriate service locations and medically necessary care. Example strategies include member education and/or incentives regarding the appropriate venue to receive emergency vs. urgent care, the use of walk-in clinics, physician extenders, ambulatory surgery centers, etc. and the applicable copayments for emergency room services (see Sections 2.2.3 and

3.2.1 of this Attachment).

Quality information about Plan providers should also be made available to members. If the Plan does not capture internal data about the quality of its providers, members can be referred to quality information compiled by credible external entities, such as the Department of Health and Human Services (Hospital Compare). Any limitations of the data about provider quality must be provided.

Plans with innovative methods for providing cost and quality information to members will receive additional points in the bidding process under this RFS.

4.3 Member Services Helpline

The Plan must maintain a statewide toll-free telephone helpline for members with questions, concerns, complaints, requests for PMP changes (if applicable) and POWER Account balance inquiries. The Plan must staff the Member Services Helpline to provide sufficient "live voice" access to its members during, at a minimum, a ten-hour business day (e.g., 8 am to 6 pm, Eastern Standard Time), Monday through Friday. The Member Services Helpline must offer language translation services for members whose primary language is not English and must offer automated telephone menu options in English and Spanish. A member services messaging option must be available after business hours in English and Spanish and member services staff must respond to all member messages by the end of the next business day. The Plan must provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members. The Plan must establish telephonic capability to transfer calls and connect the member to the DFR Hotline or Call-In Center whenever appropriate. The Plan must maintain a system for tracking and reporting the number and type of member calls and inquiries it receives during business hours and non-business hours, as this information must be reported to OMPP as described in Section 8.2 of this Attachment. The Plan must monitor its Member Services Helpline service and report its telephone service level performance to OMPP quarterly.

The Plan's Member Services Helpline staff must be prepared to respond to member concerns or issues including, but not limited to the following:

- Access to health care services
- Identification or explanation of covered services
- Procedures for submitting a member grievance or appeal
- Potential fraud or abuse
- Changing PMPs
- POWER Accounts, POWER Account balances and POWER Account cards
- Recommended age and sex appropriate preventative services
- Transfer to Hoosier Healthwise for pregnant women
- Employer contributions
- Questions about e-mail account

Upon a member's enrollment in the Plan, the Plan must inform the member about the Member Services Helpline. The Plan should encourage its members to call the Plan Member Services Helpline as the first resource for answers to questions or concerns about the Program, providers, benefits, POWER Accounts, preventative services, Plan policies, etc.

Performance targets and other measures for the Member Services Helpline are listed in Section 8.9.1 of this Attachment.

4.4 Member-Provider Communications

The Plan must not prohibit or restrict a health care professional from advising a member about his/her health status, medical care or treatment options, regardless of whether benefits for such care are provided under the Program, as long as the professional is acting within his/her lawful scope of practice. This provision does not require the Plan to provide coverage for a counseling or referral service if the Plan objects to the service on moral or religious grounds.

In accordance with 42 CFR 438.102(a), the Plan must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits and consequences of treatment or non-treatment.

The Plan must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The Plan may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Program providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered service, with the exception of services paid by a member with POWER Account funds. With the exception of services paid by a member with POWER Account funds, a provider cannot bill the member for a covered service unless the following conditions have been met:

- The service rendered must be determined to be non-covered under the Program.
- The member has exceeded the limitations for a particular service.
- The member must understand, before receiving the service, that the service is not covered under the Program, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the Program did not cover the service.

A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service.

4.5 Member Rights

The Plan must guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information in accordance with 42 CFR 438.10
- The right to be treated with respect and with due consideration for his or her dignity and privacy
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

- The right to participate in decisions regarding his or her health care, including the right to refuse treatment.

- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E.

- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

The Plan must have written policies in place regarding the protected member rights listed above. The Plan must have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Plan's members. Members must be free to exercise protected member rights, and the Plan must not discriminate against a member that chooses to exercise his or her rights.

4.6 Member Inquiries, Grievances and Appeals

The Plan must establish written polices and procedures governing the resolution of grievances and appeals. In addition to the provisions set forth in this Section, OMPP shall be adopting a uniform process for member grievances and appeals. This is required pursuant to IC 12-15-44, and will be set forth in administrative rule, which the Plan must follow.

At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures and access to the State's fair hearing system. The Plan's grievance and appeal system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with IC 27-13-10 and 27-13-10.1 (if the Plan is licensed as an HMO) or 27-8-28 and 27-8-29 (if the Plan is licensed as an accident and sickness insurer), as well as 42 CFR 438, Subpart F. The member must exhaust the Plan's appeals process prior to requesting a fair hearing with FSSA.

The term *appeal* is defined as a request for a review of an action. An *action,* as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Plan to act within the required timeframes; or
- For a resident of a rural area with only one Plan, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable).

The term *grievance,* as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "action" as defined above.

The Plan must notify the requesting provider, and give the member written notice, of any "action" taken by the Plan, including any decision by the Plan to deny a service authorization request, or to authorize a

service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing. See Section 6.2.1, Authorization of Services and Notices of Action for additional information.

The Plan must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102.

Members must be allowed to file grievances and appeals orally or in writing. However, an oral request for an appeal must be followed by a written request, unless the member is requesting expedited resolution of the appeal. The Plan must make a decision on non-expedited grievances or appeals within 20 business days of receipt of the grievance or appeal. This timeframe may be extended up to 10 business days, in accordance with IC 27-13-10-7 (if the Plan is licensed as an HMO) or 27-8-28-16 (if the Plan is licensed as an accident and sickness insurer).

The Plan must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Plan is licensed as an HMO) or 27-8-28-16 (if the Plan is licensed as an accident and sickness insurer). Notice of the resolution of an appeal must also comply with 42 CFR 438.408(e).

The Plan's internal grievance and appeals procedures must include the following components:

- The Plan must allow members 30 days from the date of action notice within which to file an appeal under the Plan's grievance and appeals procedure
- The Plan must provide assistance in completing forms
- The Plan must acknowledge receipt of each grievance and appeal

The Plan's policies and procedures governing appeals must also include provisions for the resolution of expedited appeals, including:

- Maintaining an expedited review process for appeals when the Plan or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Plan must dispose of expedited appeals within 3 business days after the Plan receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408(c). In addition to written notice, the Plan must make reasonable efforts to provide the member with oral notice of the disposition of the appeal.
- If the Plan denies the request for an expedited resolution of a member's appeal, the Plan must transfer the appeal to the standard 20 business day timeframe and give the enrollee written notice of the denial within 2 days of the expedited appeal request. The Plan must also make a reasonable attempt to give the enrollee prompt oral notice.
- The Plan must not take punitive action against a provider who requests or supports an expedited appeal on behalf of an enrollee.

FSSA maintains a fair hearing process and members must have an opportunity to appeal Plan decisions to the State. The Plan must include the FSSA fair hearing process as part of the written internal process for resolution of appeals and must describe the fair hearing process in the member handbook. The member must have an opportunity to request an FSSA fair hearing within 30 days of exhausting the Plan's internal

procedures. The member must exhaust the Plan's appeals process prior to requesting a fair hearing with FSSA.

In certain member appeals, the Plan will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.20.

4.6.1 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Plan must provide specific information regarding member grievance, appeal and State fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter a contract with the Plan. The information provided must be approved by the State and, as required under 42 CFR 438.10(g)(1), include the following:

- The right to file grievances and appeals
- The requirements and timeframes for filing a grievance or appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file a grievance or appeal by phone
- The fact that, if requested by the member and under certain circumstances: 1) Benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and 2) The member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- For a State fair hearing:
    - The right to a hearing
    - The method for obtaining a hearing; and
    - The rules that govern representation at the hearing

4.7 Oral Interpretation Services

The Plan must provide free oral interpretation services to its members in accordance with 42 CFR 438.10 (c)(4). The Plan must notify its members of the availability of these services and how to obtain them.

4.8 Cultural Competency

The Plan will be required to comply with cultural competency standards established by OMPP, which will include standards for non-English speaking, minority and disabled populations.

5.0 Provider Network Requirements

The Plan must ensure that its provider network is supported by written provider agreements, is available, is geographically accessible and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members, in accordance with 42 CFR 438.206. The Plan must also ensure that all of its contracted providers, including out-of-state providers, are IHCP providers and that they can respond to the cultural, racial and linguistic needs of the population of the Program. If the Plan permits members to receive out-of-network services,

the out-of-network providers must also be IHCP providers. The Plan will be required to participate in any State efforts to promote the delivery of covered services in a culturally competent manner.

Further information about IHCP Provider Enrollment is located at:

http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp

5.1 Network Development

OMPP requires the Plan to develop and maintain a comprehensive network for the provision of covered services to members under the Program. The Plan must develop its network, as described in Section 5.2 of this Attachment, prior to the effective date of the Plan's contract with OMPP, and must notify OMPP each time a significant change to the network occurs. Failure to demonstrate a complete and comprehensive network prior to the contract effective date may result in a delay of initial member enrollment.

With approval from OMPP, Plans that can demonstrate that they have met certain access, availability and network composition requirements may require members to use in-network providers, with the exception of self-referral providers. The Plan must provide advance notice to OMPP of significant changes to the network that may affect access, availability and network composition. OMPP reserves the right to regularly and routinely monitor network access, availability and adequacy. OMPP will impose remedies (see Section 9.1 of this Attachment) or may require the Plan to maintain an open network if the Plan does not meet its network composition requirements.

In accordance with 42 CFR 438.206(b)(1), the Plan must consider the following elements when developing and maintaining its provider network:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the Plan;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new members, if any; and
- The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by members under the Program and whether the location provides physical access for members with disabilities.

OMPP will assess liquidated damages and impose other authorized remedies for Plan non-compliance with the network development and network composition requirements.

The Plan must contract with its provider network prior to receiving enrollment. OMPP reserves the right to implement corrective actions and will assess liquidated damages as described in Section 9.1.2 of this Attachment if the Plan fails to meet and maintain provider network access standards. OMPP's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the Plan until the Plan's provider network is in place. OMPP reserves the right to monitor the Plan's PMP network. OMPP reserves the right to monitor the Plan's specialist and ancillary provider network to

confirm the Plan is maintaining the required level of access to specialty care. OMPP reserves the right to increase the number or types of required specialty providers at any time.

5.2 Network Composition Requirements

In compliance with 42 CFR 438.206, the Plan must:

- Serve the expected enrollment in the contracted service area
- Offer an appropriate range of services and access to preventative and primary care services for the population expected to be enrolled in the contracted service area
- Maintain a sufficient number, mix, and geographic distribution of providers throughout the contracted service area

The Plan must submit a network access report to confirm its provider network meets OMPP's access standards. The Plan must also submit a network access report as needed when significant changes to the network occur. Significant changes include, but are not limited to, changes in Plan services, benefits and payments, as well as enrollment of a new population in the Plan. OMPP reserves the right to expand or revise the network requirements, as it deems appropriate. The Plan must not discriminate with respect to participation, reimbursement or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification as stated in 42 CFR 438.12. However, the Plan is not prohibited from including providers only to the extent necessary to meet the needs of the Plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the Plan's responsibilities.

As required under 42 CFR 438.206, the Plan must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the Plan serves commercial members. The Plan must also make covered services available 24 hours a day, 7 days a week, when medically necessary. In meeting these requirements, the Plan must:

- Establish mechanisms to ensure compliance by providers
- Monitor providers regularly to determine compliance
- Take corrective action if there is a failure to comply

The Plan must provide OMPP written notice at least 90 calendar days in advance of the Plan's inability to maintain a sufficient network in any service area.

5.2.1 Acute Care Hospital Facilities

The Plan must provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

5.2.2 Primary Medical Care Provider (PMP) Requirements

Pursuant to 42 CFR 438.208(b), the Plan must implement procedures to deliver primary care to its members under the Program. The Plan must assure that each member has an ongoing source of primary care appropriate to the member's needs. This includes an IHCP person or entity formally designated as primarily responsible for coordinating the health care services provided to the member. OMPP requires Plans to provide access to primary care within at least 30 miles of the member's residence.

The Plan's PMP contract must state the PMP panel size limits, and the Plan must assess the PMP's non-Program practice when assessing the PMP's capacity to serve the Plan's members under the Program. OMPP reserves the right to monitor the Plan's PMP provider network to evaluate its member-to-PMP ratio and confirm the Plan's compliance with the PMP requirements outlined in this Section.

The Plan must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24-hours-a day, seven-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number 24-hours-a-day, seven-days-a-week.

The Plan must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The Plan must ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish 24-hours-a-day, seven-days-a-week.

5.2.3 Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the Plan must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers throughout the State, including but not limited to:

- Anesthesiologists
- Oncologists
- Cardiologists
- Diagnostic testing
- Gastroenterologists
- Otolaryngologists
- Physical therapists
- Speech therapists
- Occupational therapists
- Dentists
- Orthodontists
- Ophthalmologists
- Optometrists
- Psychiatrists
- Radiologists
- Pathologists
- Pulmonlogists
- Neurologists
- DME and prosthetic suppliers
- Home health providers
- Endocrinologists
- General surgeons
- Gynecologists
- Urologists
- Orthopedists
- Dermatologists
- Neurosurgeons
- Hematologists
- Infectious Disease Specialists
- Nephrologists
- Radiation Oncologists
- Rheumatologists

OMPP requires Plans to provide access to specialty care within at least 60 miles of the member's residence. In addition, the Plan must demonstrate the availability of providers with training, expertise and experience in providing smoking cessation services.

The Plan must arrange for laboratory services only through those IHCP enrolled laboratories or providers with Clinical Laboratory Improvement Amendments (CLIA) certificates.

5.2.4 Physician Extenders

Physician extenders are health care professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventative health care and education. Some can also assist in surgery and write prescriptions.

Appropriate use of physician extenders can have a positive influence on cost, quality and access and the Program encourages use of physician extenders. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventative visits or less complicated health problems, which improves access to care and may allow more patients in the Program to be seen.

Under Indiana law, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists
- Physician assistants
- Certified registered nurse anesthetists

Plans must implement initiatives to encourage providers to use physician extenders. Among other things, these initiatives should consider quality of care and patient outcomes. Examples of these types of initiatives include:

- Educate providers about the benefits of physician extenders
- Educate providers about reimbursement policies for physician extenders
- Offer financial or non-financial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.
- Collaborate with physician-extender training programs in Indiana. Collaboration could include providing internships or practicums for physician extenders, expanding the number of training slots for physician extenders, etc.

Members must be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the Plan's network. If nurse practitioner services are available through the Plan, the Plan must inform the member that nurse practitioner services are available.

As provided in IC 12-15-44-4, vision services offered by the Plan under a vision insurance rider must include services provided by optometrists.

5.2.5 Federally Qualifed Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Since Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers, OMPP strongly encourages the Plan to contract with FQHCs and RHCs that are willing to contract with the Plan and meet all of the Plan's requirements regarding the ability of these providers to provide quality services. The Plan must reimburse FQHCs and RHCs for services at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate.

OMPP requires the Plan to identify any performance incentives it offers to the FQHC or RHC. OMPP must review and approve any performance incentives. The Plan must report all such FQHC and RHC incentives which accrue during the contract period related to the cost of providing FQHC-covered or RHC-covered services to RBMC enrollees along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Plan to the FQHC or RHC. The Plan shall perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by OMPP.

Annually, OMPP requires the Plan to provide the Plan's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. In addition, OMPP requires the FQHC or RHC, and the Plan to maintain and submit records documenting the number and types of valid encounters provided to Plan enrollees each month. Capitated FQHCs and RHCs must also submit encounter data (e.g., in the form of shadow claims to the Plan) each month. The number of encounters will be subject to audit by OMPP or its representatives.

5.3 Provider Enrollment and Disenrollment

The Plan must follow procedures established by the State to enroll and disenroll providers. To process enrollment of a provider with the Plan, the Plan must submit required enrollment information to OMPP's fiscal agent.

If a PMP disenrolls from the Program, but remains an IHCP provider, the Plan must assure that the PMP provides continuation of care for his/her members in the Program for a minimum of 30 calendar days or until the member finds another source of primary care. OMPP reserves the right to immediately disenroll any provider if the provider becomes ineligible to participate in IHCP.

When appropriate, the Plan must make a good faith effort to provide written notice of a provider's disenrollment from the Plan to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice must be provided within fifteen (15) days of the Plan's receipt or issuance of the provider termination notice.

5.4 Provider Agreements

The Plan must have a process in place to review and authorize all network provider contracts. The Plan must submit a model or sample contract of each type of provider agreement to OMPP for review and approval at least 60 calendar days prior to the Plan's intended use. Sample contracts should also be submitted in each Bidder's response to this RFS.

The Plan must include in all of its provider agreements provisions to hold OMPP harmless and ensure continuation of benefits. The Plan must identify and incorporate the applicable terms of the Plan contract with OMPP and any incorporated documents, including this RFS and its Attachments. Under the terms of the provider services agreement, the provider must agree that the applicable terms and conditions set out

in this RFS, the Plan contract with OMPP, any incorporated documents, and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to enrollees.

In addition to the applicable requirements for subcontracts in Section 1.6 of this Attachment, the provider agreements must meet the following requirements:

- Describe a written provider claim dispute resolution process
- Require each provider to maintain a current IHCP provider agreement and be duly licensed in accordance with the appropriate state licensing board and must remain in good standing with said board.
- Require each provider to submit all claims that do not involve a third party payer for services rendered to the Plan's members within 180 calendar days from the date of service.
- Include a termination clause stipulating that the Plan must terminate its contractual relationship with the provider as soon as the Plan has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the Plan's members at the end of the Plan's contract under this RFS.
- Monitor providers and apply corrective actions for those who are out of compliance with OMPP's or the Plan's standards.
- Obligate the terminating provider to submit all encounter claims for services rendered to the Plan's members while serving as the Plan's network provider and provide or reference the Plan's technical specifications for the submission of such encounter data.
- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other plans.
- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Plan. Said advance notice shall not have to be more than 90 calendar days.
- The Plan must require that the contracted providers provide a copy of a member's medical record at no charge upon reasonable request by the member, and the provider must facilitate the transfer of the member's medical record at no charge to another provider at the member's request.
- Require each provider to agree that it shall not seek payment from the State for any service rendered to a member in the Program under the agreement.

The Plan must have written policies and procedures for registering and responding to claims disputes for out-of-network providers. Plans may also be asked to provide provider claims dispute resolutions to the State.

5.5 Provider Credentialing

The Plan must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current State licensure and enrollment in the IHCP. The Plan's credentialing and re-credentialing process for all contracted providers must meet the National Committee for Quality Assurance (NCQA) guidelines.

The Plan must ensure that providers agree to meet all of OMPP's and the Plan's standards for credentialing PMPs and specialists, including:

- Compliance with State record keeping requirements
- OMPP's access and availability standards
- Other quality improvement program standards

As provided in 42 CFR 438.214(c), the Plan's provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Plan must not employ or contract with providers that have been excluded from participating in Federal health care programs under Section 1128 or Section 1128A of the Social Security Act.

5.6 Medical Records

The Plan must assure that its records and those of its participating providers document all medical services that the enrollee receives in accordance with State and Federal law. The provider's medical record must include, at a minimum:

- Prescriptions for medications
- Inpatient discharge summaries
- Patient histories (including immunizations) and physicals
- A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs
- A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings

The Plan's providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed and dated and maintained for at least seven years as required by State and Federal regulations.

The Plan's providers must provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at no charge at the member's request.

Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and all other State and Federal requirements.

The Plan's providers must permit the Plan and representatives of OMPP to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards or capturing information for clinical studies. OMPP encourages Plans to use technology, including the participation in health information exchanges, where appropriate to transmit and store medical record data. See Section 7.8 in this Attachment for more information regarding electronic health records and data sharing requirements.

5.7 Provider Education and Outreach

The Plan must educate its contracted providers about the Program, POWER Accounts, POWER Account cards and recommended preventative care guidelines. The Plan must also educate its contracted providers about provider requirements and responsibilities, the Plan's prior authorization policies and procedures, member rights and responsibilities, claims dispute resolution processes, pay-for-performance programs (if any), and any other information relevant to improving the services provided to the Plan's members. Providers must be educated about co-payments for emergency room services. The Plan must explain to providers that pregnancy-related services are not covered by the Program or the Plan and must emphasize the importance of transferring pregnant women out of the Program and into Hoosier Healthwise Package B for coverage during their pregnancy.

The Plan must educate providers about reimbursement in the Program, particularly the process for receiving payment with POWER Account funds before the member's deductible has been met. The Plan must explain to providers that they will be reimbursed at the Program's rates (i.e., Medicare rates) when a member purchases covered services under the Program with POWER Account funds. Providers should understand that, in most cases, there will be sufficient funds in the member's POWER Account and the member will use his or her POWER Account card to reimburse the provider electronically and without cash at the point of service. In cases where the cost of the covered service exceeds the member's current POWER Account balance, providers should understand that the member will use his or her POWER Account card to pay for the portion of the bill that his or her POWER Account funds can cover, and that providers will be permitted to bill the Plan for the remaining balance.

The Plan must develop and include a Plan-designated inventory control number on all provider promotional, education, training or outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate OMPP's review and approval of provider materials and documentation of its receipt and approval of original and revised documents. The Plan must submit all promotional, training, educational and outreach materials designed for distribution to, or use by, contracted providers to OMPP for review and approval at least 30 calendar days prior to use and distribution. The Plan must receive approval from OMPP prior to distribution or use of materials. OMPP's decision regarding any material is final.

5.8 Plan Communications with Providers

The Plan must have in place policies and procedures to maintain frequent communications with, and provide information to, its provider network. As required by 42 CFR 438.207(c), the Plan must notify OMPP of significant changes that may affect provider procedures at least 30 calendar days prior to notifying its provider network of the changes. The Plan must give providers 45 calendar days advance notice of significant changes that may affect the providers' procedures (e.g., changes in subcontractors).

The Plan must post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with 42 CFR 438.102, the Plan must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member.

The Plan must develop and maintain a website in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers within three months of the effective date of the Plan's contract with OMPP. OMPP must pre-approve the Plan's website information and graphic presentations. The Plan may choose to develop a separate provider website or incorporate it into the home page of the member website. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Plan must date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- Plan's contact information
- Provider manuals and forms
- Claim submission information such as, but not limited to: Plan submission and processing requirements, paper and electronic submission procedures and frequently asked questions
- Provider claims dispute resolution procedures for contracted and out-of-network providers
- Prior authorization procedures
- Appeal procedures
- Entire network provider listings
- Links to OMPP's website for general information about the Program
- HIPAA Privacy Policy and Procedures

The Plan must maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. The Plan must staff the telephone Provider Helpline with personnel trained to accurately address provider issues during (at a minimum) a ten-hour business day, Monday through Friday. The Plan must maintain a system for tracking and reporting the number and type of providers' calls and inquiries. The Plan must monitor its Provider Helpline and report its telephone service performance to OMPP each quarter in a manner to be designated by the State.

The fiscal agent sponsors quarterly workshops throughout the state and an annual seminar for all IHCP providers. The Plan may be required to participate in these or other informational sessions for the Program.

5.9 Provider Payment Requirements

Plans must reimburse providers for covered services at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate.

The Plan must pay or deny electronically filed clean claims within 21 calendar days of receipt and clean paper claims within 30 calendar days of receipt. If the Plan fails to pay or deny a clean claim within these timeframes but subsequently pays the claim, the Plan must also pay the provider interest. A "clean claim" is one in which all information required for processing the claim is present. These standards apply to out-of-network claims for which the Plan is responsible and any other claims submitted by providers that have not agreed to alternate payment arrangements. As provided in 42 CFR 447.46(c)(2), the Plan may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule must be outlined in the provider contract. However, the alternate payment schedule must not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2.

The State reserves the right to adopt additional claims payment standards in administrative rules established under IC 12-15-44.

5.10 Member Payment Liability

In accordance with 42 CFR 438.106, the Plan and its subcontractors are prohibited from holding members liable for:

- Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Plan provided the services directly
- Covered services provided to the member for which OMPP does not pay the Plan
- Covered services provided to the member for which OMPP does not pay the provider that furnishes the services under a contractual, referral or other arrangement
- The Plan's debts or subcontractor's debts, in the event of the entity's insolvency

The Plan must ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Plan.

This section should not be interpreted as interfering with a Plan's or provider's ability to hold members liable for the payment of covered services with POWER Account funds before the member's deductible has been met.

5.11 Physician Incentives

5.11.1 Physician Pay for Performance

Pay for performance programs are performance-based payment systems that can offer financial and non-financial incentives to providers for meeting quality performance targets. Plans are encouraged, but not required, to establish a performance-based incentive system, especially for

high volume providers or to reward the use of physician extenders. Pay for performance programs should take into consideration clinical measures, patient outcomes and/or patient compliance.

With State approval, the Plan may determine its own methodology for incenting providers. Incentives may be financial or non-financial. However, if the Plan offers financial incentives to providers, these payments must be above and beyond the standard Program rates (i.e., Medicare rates).

5.11.2 Disclosure of Physician Incentive Plan

The Plan may implement a physician incentive plan only if:

- The Plan will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

- The Plan meets requirements for stop-loss protection, member survey, and disclosure requirements under 42 CFR 438.6.

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.6, 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans, and the Centers for Medicare and Medicaid Services (CMS) provides guidance on its website. The Plan must comply with all Federal requirements regarding the physician incentive plan and supply to OMPP information on its plan as required in the regulations and with sufficient detail to permit OMPP to determine whether the incentive plan complies with the Federal requirements. The Plan must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

5.12 Provider Directory

The Plan must provide OMPP and all Program members and potential members with the following information about its network providers:

- Lists of PMPs, the PMPs' service locations (including county), phone numbers, office hours, type of PMP (i.e., family practice, general practitioners, general internists, and gynecologists) and whether the PMPs are accepting new members

- Lists of specialty providers, their service locations (including county), phone numbers, office hours and type of specialty

- Lists of hospital providers, pharmacies, home care providers and all other network providers

- Languages spoken by the provider or the provider's office personnel

The Plan must include provider network information in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) on its member website as described in Section 4.0 of this Attachment. The Plan must list provider network information by county on the Plan's website and update

the information monthly. Network provider information must be available to print from a remote user location.

6.0 Quality Management and Utilization Management

The Plan must monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members by all providers in all types of settings, in accordance with the provisions set forth in this RFS and its Attachments. In compliance with Federal regulations, the Plan must submit quality improvement data to OMPP that includes the status and results of performance improvement projects. Additionally, the Plan must submit information requested by OMPP to complete the State's Annual Quality Assessment and Improvement Strategies Report to CMS.

6.1 Quality Management and Improvement Program

The Plan's Medical Director must be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program must have objectives that are measurable, realistic and supported by consensus among the Plan's medical and quality improvement staff. Through the Quality Management Program, the Plan must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the clinical and non-clinical services it provides to its members. As a component of its Quality Management Program, the Plan is encouraged, but not required, to develop incentive programs for both providers and members with the ultimate goals of encouraging personal responsibility to promote appropriate use of health care resources and incentivizing healthy behaviors for the purpose of improving health outcomes.

The Plan must meet the requirements of 42 CFR 438 subpart D and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its quality management program. In doing so, it shall complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects and produce quality of care reports at least annually.

The Plan's Quality Management and Improvement Program must:

- Include developing and maintaining an annual quality improvement plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Have in effect mechanisms to detect both underutilization and overtutilization of services.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities and assessment of quality improvement activities requested by OMPP.

- Participate appropriately in clinical studies, and use Health Plan Employer Data and Information Set® (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.

- Collect measurement indicator data related to areas of clinical priority and quality of care. Examples of potential areas of clinical priority include:

  - Emergency room utilization
  - Access to care
  - Asthma
  - Obesity
  - Preventative service utilization
  - Smoking cessation

- Report any national performance measures developed by CMS. The Plan must develop an approach for meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.240(a)(2).

- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.

- Contract for an NCQA-accredited HEDIS audit and report audited HEDIS rates.

- Conduct a Consumer Assessment of Health Plans (CAHPS) survey and report survey results to OMPP annually.

- Participate in other quality improvement activities to be determined by OMPP.

6.1.1 Quality Management and Improvement Committee

The Plan must establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and annual workplan. The Plan's Medical Director must be an active participant in the Plan's internal Quality Management and Improvement Committee. The committee must be representative of management staff, Plan departments and community partners, advocates, members and subcontractors, as appropriate. Subcontractors providing direct services to members must be represented on the committee.

The Plan must have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Plan's internal Quality Management and Improvement Committee and Quality Management and Improvement Work Plan. All functional units in the Plan's organizational structure must integrate their performance measures, operational activities and outcome assessments with the Plan's internal Quality Management and Improvement Committee to support the Plan's quality management and improvement goals and objectives.

6.1.2 Quality Management and Improvement Work Plan Requirements

The Plan's Quality Management and Improvement Committee, in collaboration with the Plan's Medical Director, must develop an annual Quality Management and Improvement Work Plan. The Quality Management and Improvement Work Plan must identify the Plan's quality

management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. The Plan must submit its Quality Management and Improvement Work Plan to OMPP during the readiness review and annually thereafter.

6.1.3 External Quality Review

Pursuant to Federal regulation, the State must arrange for an annual, external independent review of each Plan's quality of, timeliness of and access to health care services. The Plan's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

6.2 Utilization Management Program

The Plan must operate and maintain its own utilization management program. The Plan may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The Plan is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition.

The Plan must establish and maintain medical management criteria and practice guidelines, in accordance with Federal and State regulations, that are based on valid and reliable clinical evidence or consensus among clinical professionals and that consider the needs of the Plan's members. In developing practice guidelines, the Plan must consult with contracting health care professionals. The Plan must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate. The Plan must have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the Plan's members. The Plan must periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members upon request.

The Plan is also encouraged to monitor utilization through retrospective reviews. As part of its utilization review, the Plan must monitor utilization of preventative care services regularly and frequently, in addition to HEDIS requirements. The Plan should also monitor access to preventative care, specifically to identify members who are not accessing preventative care services in accordance with the recommended preventative care standards established by OMPP. The Plan is responsible for educating members regarding the importance of using preventative care services in accordance with OMPP's preventative care standards.

The Plan must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services, drug utilization, preventative care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor performance data, facilitate program management and long-term quality and identify critical quality of care issues. The Plan's utilization management program policies and procedures must meet all American Accreditation HealthCare Commission, Inc. (URAC) standards and must include appropriate timeframes for:

- Completing initial requests for prior authorization of services
- Completing initial determinations of medical necessity
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per State law
- Notifying providers and members of the Plan's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying providers and members of the Plan's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The Plan must report its medical necessity determination decisions, and must describe its prior authorization and emergency room utilization management processes, to OMPP.

6.2.1 Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The Plan must not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. OMPP reserves the right to audit Plan denials, appeals and authorization requests. OMPP may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Plan may be required to comply with such waivers and will be provided with prior notice by OMPP.

As part of the utilization management function, the Plan must facilitate PMPs' requests for authorization for primary and preventative care services and must assist the PMP in providing appropriate referral for specialty services by locating resources for appropriate referral. In accordance with Federal regulations, the process for authorization of services must comply with the following requirements:

- Second Opinions: In accordance with 42 CFR 438.206(b)(3) the Plan must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the Plan must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.
- Women's Health: In accordance with 42 CFR 438.206(b)(2), the Plan must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Plan must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits. The Plan may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

The Plan must notify the requesting provider, and provide a written notice to the member, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404, although the notice to the requesting provider does not need to be in writing. The notice must be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c). If the Plan does not make a decision within the required timeframe, the Plan must notify the member on the last day of the timeframe that it has not made a decision. An untimely decision constitutes a denial and is considered an adverse action.

The Plan must provide notice of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed 14 calendar days after the request for services. An extension of up to 14 calendar days is permitted if the member or provider requests an extension or if the Plan justifies a need for more information and explains how the extension is in the member's best interest. The Plan will be required to provide its justification to OMPP upon request. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

For situations in which a provider indicates, or the Plan determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service. The Plan may extend the three (3) business days by up to 14 calendar days if the member requests an extension or the Plan justifies a need for additional information and how the extension is in the best interest of the member. The Plan will be required to provide its justification to OMPP upon request.

The Plan must notify members of decisions to terminate, suspend, or reduce previously authorized covered services under the Program at least ten (10) calendar days before the date of action, with the following exceptions:

- Notice is shortened to five (5) calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.
- Notice may occur no later than the date of the action in the event of:
  - The death of a member;
  - The Plan's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information);
  - The member's address is unknown and mail directed to him/her has no forwarding address;
  - The member's acceptance of Medicaid or other health care coverage;
  - The member's physician prescribes the change in the level of medical care;

The notification letters used by the Plan must be approved by OMPP, meet the requirements of 42 CFR 438.10(c) and (d) and Section 4.2 of this Attachment regarding language, oral interpretation and format for member materials, and must clearly explain the following:

- The action the Plan or its contractor has taken or intends to take
- The reasons for the action
- The member's right to file an appeal with the Plan and the process for doing so
- After the member has exhausted the Plan's appeal process, the notice must contain the member's right to request an FSSA Hearing and the process for doing so
- Circumstances under which expedited resolution is available and how to request it
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services

6.2.2 Objection on Moral or Religious Grounds

If the Plan elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):

- To OMPP with its application for a contract under this RFS
- To OMPP if it adopts the policy during the term of the contract
- To potential members before and during enrollment in the Plan
- To members within 90 calendar days after adopting the policy with respect to any particular service

6.2.3 Utilization Management Committee

The Plan must have a utilization management committee directed by the Plan's Medical Director. The committee is responsible for:

- Monitoring providers' requests for rendering health care services to its members
- Monitoring the medical appropriateness and necessity of health care services provided to its members
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task

- Confirming the Plan has an effective mechanism in place for a Plan provider or Plan representative to respond within one hour to all emergency room providers 24-hours-a-day, seven-days-a-week:

  - After the Plan's member's initial emergency room screening; and,

  - After the Plan's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

6.3 Program Integrity Plan

Pursuant to 42 CFR 438.608, the Plan must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. This plan must be updated annually and submitted to OMPP as part of the Plan's Quality Management and Improvement Work Plan.

The Plan must include the following in its Program Integrity Plan:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards

- The designation of a compliance officer and a compliance committee that are accountable to senior management

- The type and frequency of training and education for the compliance officer and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, as directed by CMS.

- Effective lines of communication between the compliance officer and the organization's employees

- Enforcement of standards through well-publicized disciplinary guidelines

- Provision for internal monitoring and auditing

- Provision for prompt response to detected offenses, and for development of corrective action initiatives

The Plan must immediately report any suspicion or knowledge of fraud and abuse including, but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent. The Plan must report provider fraud to OMPP, the Indiana Medicaid Fraud Control Unit (IMFCU) and the Surveillance and Utilization Review Unit (SUR). The Plan must report member fraud to OMPP, the SUR, the Indiana Bureau of Investigation and the Office of the Inspector General.

The Plan must not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the IMFCU and OMPP and must cooperate fully in any investigation by the IMFCU or subsequent legal action that may result from such an investigation.

If subsequent investigation or legal action results in a monetary recovery to OMPP, the reporting Plan will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The Plan's share of recovery will be as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, and its actual documented loss (if any). The State will pay to the Plan the remainder of the recovery, not to exceed the Plan's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Plan about potential settlement. The State may consider the Plan's preferences or opinions about acceptance, rejection, or the terms of a settlement, but they are not binding on the State.

- If final resolution of a matter does not occur until after the contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Plan shall survive expiration of the contract and remain in effect until final resolution of a matter referred to the IMFCU by the Plan under this section.

If the State makes a recovery in a matter where the Plan has sustained a documented loss but the case did not result from a referral made by the Plan, the recovery will be distributed in accordance with the terms of this section.

As part of the annual Quality Management and Improvement Work Plan Report, the Plan must include program integrity activities. The work plan must detail program integrity-related goals, objectives and planned activities for the upcoming year.

7.0 Information Systems

The Plan must have an Information System (IS) sufficient to support the Program's requirements, and the Plan must submit all required data and reports in the format specified by OMPP. The Plan must have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164).

The Plan's IS must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements, Privacy and Security Rule standards. The Plan's electronic mail encryption software for HIPAA security purposes must be the same as the State's. The Plan's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308)
- Physical safeguards (45 CFR 164.310)
- Technical safeguards (45 CFR 164.312)

The Plan must maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this RFS. Examples of Performance Reporting elements that will be required by the State include:

- Information must be provided on areas including, but not limited to, utilization, grievances and appeals, and disenrollments

- Data on member and provider characteristics, as specified by OMPP, and on services furnished to enrollees through a shadow claims data system

The Plan must make data available to OMPP and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, the Plan must submit all data, including shadow claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director), certifying the accuracy, truthfulness and completeness of the Plan's data.

The Plan must comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http://www.in.gov/iot/. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

7.1 Disaster Recovery Plans

Information system contingency planning shall be developed in accordance with 45 CFR 164.308. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures must also be addressed. The Plan must protect against hardware, software and human error. The Plan must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Plan must maintain full and complete back-up copies of data and software, and must back up on tape or optical disk and store its data in an off-site location approved by OMPP. The Plan must maintain or otherwise arrange for an alternate site for its system operations in the event of a disaster.

For purposes of this RFS, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Plan's or its subcontracting entities' information system or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Plan must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Plan will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

The Plan's responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.

- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.

- Demonstrating an ability to meet back-up requirements by submitting and maintaining Data Backup and Disaster Recovery Plans that address:

  - Checkpoint and restart capabilities and procedures

- Retention and storage of back-up files and software
- Hardware back-up for the servers
- Hardware back-up for data entry equipment
- Network back-up for telecommunications

- In the event of a catastrophic or natural disaster, resuming normal business functions at the earliest possible time, not to exceed 30 calendar days. If deemed appropriate by the State, coordinating with the State's fiscal agent to restore the processing of claims by Indiana*AIM* if the claims processing capacity cannot be restored within the Plan's system.

- In the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, resuming normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

- Developing coordination methods for disaster recovery activities with OMPP and OMPP's fiscal agent, as well as DFR and its contractors.

- Providing the State with business resumption documents, reviewed and updated at least annually, such as:

  - Disaster Recovery Plans
  - Business Continuity and Contingency Plans
  - Facility Plans
  - Other related documents as identified by the State

7.2 Member Enrollment Data Exchange

The Plan is responsible for verifying member eligibility data and reconciling it with capitation payments and the State's POWER Account contribution for each eligible member. The Plan must reconcile its eligibility, capitation and POWER Account records monthly. If the Plan discovers a discrepancy in eligibility, capitation or POWER Account information, the Plan must notify OMPP and the State's fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after OMPP delivers the eligibility records. The Plan must return any capitation and/or POWER Account overpayments to OMPP. If the Plan receives enrollment information, a capitation payment and/or the State's POWER Account contribution for a member, the Plan will be financially responsible for the member as soon as the member makes his or her first POWER Account contribution and, if the contribution is paid by check, the check clears.

The Plan must accept enrollment data in electronic format, currently via secure FTP, as directed by OMPP. The Companion Guide – 834 MCO Benefit Enrollment and Maintenance Transaction details the enrollment data exchange. The Plan is responsible for loading the eligibility information into its claims system within five calendar days of receipt.

Plan will fully accept and utilize the 12-position RID number no later than July 1, 2008.

7.3 Provider Network File

At the beginning of the contract, and on a monthly basis, the Plan must notify OMPP's fiscal agent via file submission of all providers, including primary, specialty and ancillary providers, enrolled in its network. For more information regarding provider network data, see Section 5.0 of this Attachment.

7.4 Claims Processing

7.4.1 Claims Processing Capability

The Plan must demonstrate and maintain the capability to process and pay provider claims for services rendered to the Plan's members, in compliance with HIPAA, including National Provider Identification (NPI). The Plan must be able to price specific procedures or encounters (depending on the agreement between the provider(s) and the Plan) and to maintain detailed records of remittances to providers. OMPP must pre-approve the Plan's delegation of any claims processing function to a sub-contractor, and the Plan must notify OMPP and secure OMPP's approval of any change to sub-contracting arrangements for claims processing.

The Plan must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to OMPP for review and approval. Although Plans can set more stringent internal standards, at a minimum, the State requires the Plan to meet a standard of no less than 95 percent claims processing accuracy and 95 percent financial accuracy.

The out-of-network provider filing limit for submission of claims to the Plan is 12 months from the date of service.

7.4.2 Compliance with State and Federal Claims Processing Regulations

The Plan must have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Plan's system must process all claim types such as professional, institutional and pharmacy claims. The Plan must comply with applicable claims processing standards and confidentiality standards under State and Federal law, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Plan must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers. The Plan is prohibited from requiring out-of-network providers to establish a Plan-specific provider number in order to receive payment for claims submitted.

7.4.3 Claims Payment Timelines

The Plan must pay or deny electronically filed clean claims within 30 calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Plan must pay or deny clean paper claims within 45 calendar days of receipt. If the Plan fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Plan must also pay the provider interest. The Plan must pay interest on all clean claims paid late (i.e., in- or out-of-network claims) for which the Plan is responsible, unless the Plan and provider have made alternate written payment arrangements.

As provided in 42 CFR 447.46(c)(2), the Plan may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule must be outlined in the provider contract. However, the alternate payment schedule must not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2.

The State reserves the right to adopt additional claims payment standards in administrative rule. The State also reserves the right to perform a random sample audit of all claims, and expects the audited Plan to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

7.5 POWER Accounts

The Plan will be required to have polices, procedures and mechanisms in place to support accuracy, security and privacy in the Plan's administration of member POWER Accounts. The State will require account balance reporting, and reserves the right to require more frequent POWER Account balance reporting then set forth in Section 8.8 of this Attachment.

7.6 Shadow Claims Submission

The Plan must have policies, procedures and mechanisms in place to support the shadow claims reporting process described below. The Plan must report any problems it is experiencing with shadow claims submission to its designated OMPP Policy Analyst. The HIPAA Claims Companion Guides provide detailed instructions to guide the Plan in reporting shadow claims data.

7.6.1 Definition and Uses of Shadow Claims

The Plan must submit a shadow claim to the State's fiscal agent for every service rendered to a member for which the Plan either paid or denied reimbursement. Shadow claims are reports of individual patient encounters. These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis.

The State will use these shadow claims in evaluating the Program and in making tactical and strategic decisions related to the Program and to the State's contract with each Plan. For example, the State will use shadow claims data to calculate capitation rates, to calculate incentive payments to the Plan (if any) and to assess the Plan's contract compliance. See Section 9.2.2 of this Attachment for a schedule of liquidated damages that OMPP will assess for non-compliance with shadow claims submission requirements.

7.6.2 Reporting Format and Batch Submission Schedule

The Plan must submit institutional and professional shadow claims data in an electronic format that adheres to the data specifications in the Companion Guide-837 Institutional and Professional Claim and Encounter Transaction and any other State or Federally mandated electronic claims submission standards. The Plan must submit pharmacy shadow claims data in an electronic format that adheres to the data specifications in the HIPAA Claims Companion Guides and any other State or Federally mandated electronic claims submission standards.

The Plan must submit via secure FTP at least one batch of shadow claims for institutional, professional and pharmacy claims before 5 pm on Wednesday each week. OMPP will use an overall average of calendar month submissions to assess compliance with this shadow claim submission requirement. The State will require the Plan to submit a corrective action plan and will assess liquidated damages for failure to comply with the shadow claims submission requirements. See Section 9.2.2 of this Attachment for a schedule of liquidated damages that OMPP will assess for non-compliance with shadow claims submission requirements.

7.6.3 Shadow Claims Quality and Performance Measures

The Plan must have written policies and procedures to address its submission of shadow claims to the State. At least annually, or on a schedule determined at the discretion of the State, the Plan must submit a shadow claims workplan that addresses the Plan's strategy for monitoring and improving the following:

- Timeliness of Plan's Shadow Claims Submission to the State's Fiscal Agent: The Plan must submit all shadow claims within 15 months of the earliest date of service on the claim. The Plan must submit void/replacement claims within two years from the date of service. In addition, the Plan must submit 100 percent of its adjudicated claims within 30 days of adjudication. The State will require the Plan to submit a corrective action plan to address non-compliance issues and will assess liquidated damages if the Plan fails to comply with these timeliness requirements.

- Compliance with Pre-cycle Edits: OMPP's fiscal agent will assess each shadow claim for compliance with pre-cycle edits. The Plan must have 98 percent of each shadow claims batch pass all pre-cycle edits. The Plan must then correct and resubmit any shadow claims that did not pass the pre-cycle edits. The fiscal agent will include each shadow claims batch in the overall average of calendar month batch submissions. For submissions that fall below the 98 percent standard, OMPP will assess liquidated damages per claim type, in accordance with the schedule in Section 9.2.2 of this Attachment.

- Accuracy of Shadow Claims Detail: The Plan must demonstrate that it implements policies and procedures to ensure that shadow claims submissions are accurate; that is, that all shadow claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Plan's internal standards and all State and Federal requirements. OMPP reserves the right to monitor Plan shadow claims for accuracy against the Plan's internal criteria and its level of adjudication accuracy. OMPP will regularly monitor the Plan's accuracy by reviewing the Plan's compliance with its internal policies and procedures for ensuring accurate shadow claims submissions and by performing a random sample audit of all claims. OMPP expects the Plan to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. OMPP will require the Plan to submit a corrective action plan and will require non-compliance remedies for the Plan's failure to comply with shadow claims accuracy reporting standards in accordance with Section 9.2 of this Attachment.

- Completeness of Shadow Claims Data: The Plan must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims

submissions. The Plan must also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

As part of its annual shadow claims workplan, the Plan must demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. OMPP may require the Plan to demonstrate, through report or audit, that this monitoring system is in place and that the Plan is regularly monitoring the completeness of claims and encounter data and ensuring that the Plan is meeting OMPP's completeness requirements as described in this RFS and its Attachments.

Additionally, in an effort to increase the completeness of Plan shadow claims submissions, OMPP will evaluate the Plan's submitted shadow claims volume and will calculate the average number of claims submitted per member per month for the Plan. OMPP will identify performance targets annually and may adjust the targets to reflect changes in Plan shadow claims submission rates. OMPP will require the Plan to submit a corrective action plan and will require non-compliance remedies for the Plan's failure to comply with shadow claims completeness reporting standards in accordance with Section 9.2 of this Attachment.

7.7 Third-Party Liability (TPL) Issues

7.7.1 Coordination of Benefits

If a member enrolled with the Plan under the Program is also enrolled or covered by a casualty insurer, such as workman's compensation insurance or automobile insurance, the Plan is responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The Plan must share information regarding its members with other Plans and other insurance payers as specified by OMPP and in accordance with 42 CFR 438.208(b). In the process of coordinating care, the Plan must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164.

The Plan may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the enrollee or on behalf of the enrollee.

7.7.2 Collection and Reporting

The Plan will be responsible for identifying and collecting third-party liability coverage. Plans may be required to report third-party collections information to the State. The Plan may keep ten percent (10%) of all funds it collects from third-party payors and shall transfer the remaining ninety percent (90%) to the State within 30 days of collection.

7.7.3 Cost Avoidance

The Plan's third-party liability responsibilities include cost avoidance. When the Plan is aware of casualty insurance coverage prior to paying for a health care service for an enrollee, it should avoid payment by rejecting a provider's claim and direct that the provider first submit the claim to the appropriate third party.

If a member obtains health care coverage under another health insurance policy or program, the State will disenroll the member from the Program. For this reason, if the Plan identifies members who have newly discovered health insurance, the Plan must provide the State and its fiscal agent the following information:

- Member name/recipient identification number/Social Security number
- Carrier name/address/phone number/contact person
- Policyholder name/address/Social Security number/relationship to enrollee
- Policy number/effective date/coverage type

If insurance coverage information is not available, or if one of the exceptions to the cost avoidance rule discussed in this section applies, then the Plan must make the payment and make a claim against the third-party, if it is determined that the third-party is or may be liable. The Plan must ensure that its cost avoidance efforts do not prevent an enrollee from receiving medically necessary services in a timely manner.

7.7.4 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139 include the following situation in which the Plan must first pay the provider and then coordinate with the liable third-party: The claim is for services provided that were covered by a third-party at the time services were rendered or reimbursed (i.e., the Plan was not aware of the third party coverage). In this case, the Plan must pursue reimbursement from potentially liable third parties.

7.8 Health Information Technology and Data Sharing

The use of Health Information Technology (HIT) has the potential to improve the quality and efficiency of health care delivery in numerous ways. Digitizing and sharing health care data can reduce medical errors, increase efficiency, decrease duplicative or unnecessary services and reduce fraud and abuse. Additionally, HIT initiatives are important in improving the data quality necessary for public health research, evidenced-based decision-making, population health management and reduction of manual, labor-intensive monitoring and oversight.

Plans are encouraged, but not required, to develop, implement and participate in healthcare information technology (HIT) and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana.

To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health, and others, organizations at the national level, including the Health IT Standards Panel and the Certification Commission for Health IT, are working to develop standards related to IT architecture, messaging, coding, and privacy/security and a certification process for technologies. The Plan is encouraged to use these standards in developing their electronic data sharing initiatives, if any.

The following are examples of types of HIT initiatives that the Plan may consider developing:

- Electronic prescribing (e-prescribing)

  In a basic e-prescribing system, providers use computers to enter prescriptions. In addition, e-prescribing may include: electronic access to clinical decision support information,

including clinical guidelines and formulary information; electronic connectivity between clinicians, pharmacies and health plans, in order to transmit prescriptions, verify eligibility and benefits and process renewal requests; integration with an electronic medical record for access to information such as medical conditions, current and prior medications, allergies and laboratory results.

- Electronic medical record (EMR)

  An electronic medical record provides for electronic entry and storage of patients' medical record data. Depending on the local information technology infrastructure, EMRs may also allow for electronic data transmission and data sharing. More complex EMRs can integrate computerized provider order entry (CPOE) and e-prescribing functions.

- Inpatient computerized provider order entry (CPOE)

  CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient's medical history.

- Health information exchanges (including regional health information organizations – RHIOs)

  These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared fully integrated medical records.

- Benchmarking

  Plans can pool data from multiple providers and "benchmark" or compare metrics related to outcomes, utilization of services and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with Plans and providers to help them identify opportunities for improvement, or can be linked to pay for performance initiatives.

- Telemedicine

  Telemedicine allows provider-to-provider and provider-to-member live interactions, and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating complex patients in the Program. Plans are encouraged to develop reimbursement mechanisms to encourage appropriate use of telemedicine.

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that Plans can adopt to participate directly and to incent providers to participate in HIT. Some examples include:

- Contract or affiliate with existing health information exchanges and information networks

- Develop coalitions with other health care providers to develop health information exchanges and information networks

- Develop proposals for health information exchanges and information networks, and apply for grants to support those proposals

- Require high-volume providers to participate in one of Indiana's established health data exchanges or information networks, in regions where those networks are currently established.

- Require high-volume prescribers to use some level of e-prescribing, in regions where an infrastructure to support e-prescribing exists.

- Require high-volume providers to use EMRs

- Identify providers that are and are not currently participating in information networks or using EMRs, e-prescribing, CPOE or other HIT in order to focus incentives.

- Offer incentives to providers for adopting HIT, such as

  - Provide free or subsidized handheld devices to physicians for electronic prescribing

  - Provide financial or non-financial incentives to providers who adopt EMRs or electronic prescribing

8.0 Performance Reporting and Incentives

The State places great emphasis on the delivery of quality health care to members in the Program, and performance monitoring and data analysis are critical components in assessing how well the Plan is maintaining and improving the quality of care. The State reserves the right to use various performance targets, industry standards, national benchmarks, and Program specific standards in monitoring the Plan's performance and clinical outcomes. The Plan must submit Program specific performance data unless otherwise specified by OMPP. The State will publish Program performance data and will recognize the Plan when it exceeds performance indicators.

Plan reporting and data analysis will be a critical piece of the process used to evaluate the Program. The Program is the nation's first large scale experiment with a deductible health plan paired with a health spending account, for a low-income population and the State and CMS will be evaluating the success of the program pursuant to the terms of the Section 1115 waiver that the State plans to operate the program under.

The Plan must comply with all reporting requirements and must submit the requested data completely and accurately within the requested timeframes and in the formats identified by OMPP. The Plan must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to OMPP and the monitoring contractor is accurate. The Plan must submit its performance data and reports under the signatures of either its Financial Officer or Executive Officer (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Plan's data.

OMPP reserves the right to audit the Plan's self-reported data and change reporting requirements at any time with reasonable notice. OMPP may require corrective actions and will assess liquidated damages, as specified in Section 9.1.2 of this Attachment, for Plan non-compliance with these and subsequent reporting requirements and performance standards. OMPP may change the frequency of reports and may require additional reports with reasonable advance notice to the Plan.

8.1 Financial Reports

Plans must meet IDOI licensure and financial requirements, and OMPP must be copied on any reports submitted to IDOI. The Financial Reports include but are not necessarily limited to:

- Duplicates of all required IDOI Filings (as required by IDOI)
- Third-party liability collections (ad hoc)
- Physician Incentive Plan Disclosure, if applicable (Annually)

Third-Party Liability Collections reports may also be required by the State on a quarterly basis.

8.2 Member Service Reports

Member Service Reports identify the methods the Plan uses to communicate to members about preventative health care and program services and to monitor member satisfaction. The Member Service Reports include but are not necessarily limited to:

- Member Helpline Performance Report (Monthly)
- Member Grievances Report (Monthly)
- Member Grievances Log (Monthly)
- Member Appeal Report (Monthly)
- Member Appeals Log (Monthly)
- FSSA Hearing and Appeals (Ad Hoc)
- Summary of Consumer Assessment of Health Plans Survey (CAHPS) (Annually). *Note: In conducting the survey, the Plan may be required to add additional questions regarding member satisfaction with the Program, POWER Accounts and the use of POWER Account cards.*
- Member Outreach Plan (Ad Hoc)
- Member Outreach Activities Report (Semi-annually in Year One, Annually thereafter)
- Prior Authorization Approvals and Denials (Monthly)

8.3 Network Development Reports

Network Development Reports assist OMPP in monitoring the Plan's network composition by specialty and geoaccess ratios in order to assess member access and network capacity. The Plan must identify current enrollment, gaps in network services and the corrective actions that the Plan is taking to resolve any potential problems relating to network access and capacity. The Network Development Reports include but are not necessarily limited to:

- Provider Directory (Annually)
- Network Geographic Access Assessments
  - Pharmacy (Annually)
  - PMPs (Quarterly)

  - Specialists (Annually)
  - Behavioral Health Providers (Annually)
- 24-Hour Availability Audit (Annually)
- Subcontractor Compliance Summary Report (Annually)
- Provider Promotions, Education, and Outreach (at OMPP's request)
- Provider Network Data File (upon commencement of the contract, and as changes are made; once Plan demonstrates satisfactory network stability, then monthly)

8.4 Provider Service Reports

Provider Service Reports assist OMPP in monitoring the methods the Plan uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program. The Provider Service Reports include but are not necessarily limited to:

- Provider Helpline Performance Report (Monthly)
- Provider Disputes (Formal and Informal) (Monthly)
- Formal Provider Disputes Log (Monthly)
- Binding Arbitration (Ad Hoc)

8.5 Quality Management Reports

Quality Management Reports document the methods and processes the Plan uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist OMPP in monitoring the Plan's quality management and improvement activities. The Quality Management Reports include but are not necessarily limited to:

- Quality Management and Improvement Program Workplan – includes Program Integrity Workplan, Shadow Claims Workplan and Provider Network Development Activity Report (Quarterly)
- Quality Management Committee Meeting Minutes (aggregate plan/product information from Plan) (Ad Hoc)
- HEDIS Baseline Assessment Tool (Annually)
- HEDIS Data Submission Tool (Annually)
- HEDIS Compliance Auditor's Final Report (Annually)

8.6 Utilization Reports

Utilization Reports assist OMPP in monitoring the Plan's utilization trends and also help assess the Plan's stability and continued ability to offer health care services to its members. The Utilization Reports include but are not necessarily limited to:

- Capitation Rate Calculation Sheet (Semi-annually)
- Service Utilization – Including preventative services utilization (Quarterly)

8.7 Claims Reports

Claims Reports assist OMPP in monitoring the Plan's claims and encounter data processing activities to ensure appropriate member access to services and payments to providers. The Plan must submit claims

and shadow claims processing and adjudication data. The Plan must also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing and shadow claims submission. The Plan must submit the following data and reports:

- Shadow Claims/Encounter Data Submissions (Weekly, to fiscal agent)
- Adjudicated Claims Inventory Summary – includes Claims Aging Summary and Claims Lag Report (Quarterly)
- Top 10 Claims Denial Reasons (Monthly)
- Claims Processing Summary – includes Outstanding Claims Inventory Summary and Interest Paid on Claims (Quarterly)

8.8 Other Reporting

OMPP will be collecting various other reports to help evaluate the Program's effectiveness, including its ability to expand access to health insurance, improve health outcomes, encourage personal responsibility and motivate healthy behaviors. These reports are likely to include the following information:

- Enrollment and Disenrollment Reports
  - Member Enrollment and Disenrollment Reports (including disenrollment reasons) (Quarterly)
- Geographic coverage reports
  - PMP enrollment by county (Monthly)
- POWER Account Reports
  - Aggregate POWER Account Contribution Detail (Quarterly)
  - Amount of Employer Contributions and Participating Employer Information (Annually)
  - Payments Made by Insurers Due to Lack of POWER Account Funds (Monthly)
  - Non-payment of POWER Account Contributions (including non-sufficient funds) (Monthly)
  - Unspent POWER Account Balance and Roll-Over Summary (Annually in Year One, Quarterly thereafter)
  - Member POWER Account Balance Information (Monthly)
- Spending Summaries
  - Total spending by source and service (Quarterly)
  - Reimbursement for FQHC and RHC Services (Qnnually)
  - Top 25 Most Costly Conditions (Annually)
- Other Reports
  - Buy-in Product Participation (Monthly)
  - Disease Management Report (Annually)
  - ESP Referrals by Insurers (Monthly)
  - Benefit Design (Semi-annually in Year One, Annually thereafter)
  - Key Staff and Other Staffing (as changes occur)
  - Summary of Member Compliance with Recommended Preventive Care Services (Annually)
- Other Reports, Individual
  - Members Who Have Reached Annual Benefits Cap (include members within certain threshold) (Monthly)
  - Members Who Have Reached Lifetime Benefits Cap (include members within certain threshold) (Monthly)
  - Pregnancy Identification (Monthly)

OMPP reserves the right to require additional reports to address program-related issues that are not anticipated at the time of the RFS release but are determined by OMPP to be necessary for Program monitoring and evaluation.

8.9 Performance Monitoring and Incentives

Data submitted by the Plan are the primary source of data the State uses in its monitoring efforts. These data come to the State in various formats and at different times. The data may be transmitted as an aggregate report, specific data elements, or via encounter data. OMPP and its monitoring contractor will review the Plan's data and compare the results to established performance targets, e.g., Program standards, national benchmarks or industry standards.

OMPP reserves the right to implement incentives to reward any Plan whose performance is consistently above the targets for the majority of the measures listed below. OMPP also will assess liquidated damages or apply other remedies listed in Section 9.0 for failure to meet the minimum standards listed below.

8.9.1 Administrative Performance Targets, Standards, and Benchmarks

Listed below are the current performance indicators and the performance target for each measure. OMPP reserves the right to identify additional performance indicators and targets.

A. Customer Helpline Metrics

1. At least 97% (ninety-seven percent) of all phone calls to the Member Services Helpline shall reach the call center menu within 30 (thirty) seconds. If calls are handled through an automated call distribution system, that system must be suitable to and approved by the State.

2. At least 85% (eighty-five percent) of calls shall be answered by a Member Services Helpline representative within 30 seconds after the call has been routed through the call center menu. 95% (ninety-five percent) of calls shall be answered within 60 seconds. If no automated call distribution system exists, 95% (ninety-five percent) of calls shall be answered within 30 seconds. "Answered" means that the call is picked up by a qualified Member Services Helpline staff person.

3. The busy rate shall not exceed 0% (zero percent).

4. The lost call (abandonment) rate shall not exceed 5% (five percent).

5. An answering machine, voice mail or answering service must be available for after-hours calls. One hundred percent (100%) of after-hours calls must be returned within the next business day.

6. The Member Services Helpline must be equipped with the appropriate technology to accept calls from all members. The Plan is responsible for ensuring that people with limited English proficiency and those who are deaf, hearing impaired or have other special needs have access to communication services that enable all members to utilize the Member Services Helpline.

7. 85% (eighty-five percent) of all issues from callers should be resolved during the initial call. If information cannot be provided to a caller in a timely manner, the Member Services Helpline representative should request a name, phone number and/or addresses (if necessary) and respond to the caller within one business day from the time of contact.

B. Access

1. Ninety-eight percent of the Plan's members must have pharmacy access within 30 miles of the member's residence.

2. Ninety percent of all of the Plan's members shall have access to at least two providers of each required specialty type within 60 miles of the member's residence. See Section 5.2 for more detailed information regarding access standards.

C. Grievances

1. All member grievances will be resolved within 20 business days of receipt.

D. Operations

1. On a quarterly basis, the rolling year-to-date average medical cost ratio will be equal to or greater than 85% of revenue.

E. Plan Solvency

1. On a quarterly basis, current ratio (assets to liability) will be greater than or equal to one.

2. On a quarterly basis, the number of days cash on hand will not be fewer than 60 business days. Plans may not count POWER Account balances as cash on hand. OMPP reserves the right to adjust the required number of days of cash on hand based on historical Plan performance and the ability of the Plan to demonstrate solvency.

3. On a quarterly basis, days in unpaid claims will not be greater than 65 business days.

4. On a quarterly basis, days in claims receivables will not be greater than 30 business days.

5. On a quarterly basis, equity (net worth) will be maintained at or above $50 per member.

F. POWER Account Performance

1. Funds deposited by the State must be credited to a member's account within 2 calendar days.

2. Member contributions via direct deposit or payroll withholding must be available for member use within 2 calendar days of deposit.

3. Member contributions via mailed paper check must be available for member use within 5 calendar days after the check has cleared. Member contributions via money order must be available for member use within 5 calendar days of payment receipt.

4. In the event that a member loses eligibility, the Plan will refund the State the balance of their POWER account in 5 days.

G. Shadow Claims Submission

1. The Plan must submit via secure FTP at least one batch of shadow claims for institutional, professional and pharmacy claims before 5 pm on Wednesday each week

2. The Plan must submit all shadow claims within fifteen months of the earliest date of service on the claim.

3. The Plan must submit void/replacement claims within two years from the date of service.

4. The Plan must submit 100 percent of its adjudicated claims within 30 days of adjudication.

5. The Plan must have 98 percent of each shadow claims batch pass pre-cycle edits.

6. All shadow claims data must be accurate and complete (i.e. have no missing encounters or required data elements)

8.9.2 Clinical Performance Targets, Standards, and Benchmarks

OMPP will establish clinical performance targets, standards, and benchmarks based on the goals of the program and data collected during the operation of the program.

8.9.3 Provider and Member Incentive Programs

Plans are encouraged, but not required, to establish a performance-based incentive system for providers, such as high volume PMPs. Incentives may be financial or non-financial, but the State must approve the Plan's methodology for incenting providers. The State encourages creativity in designing pay for performance programs.

Plans are also encouraged, but not required, to establish a program to encourage members' personal responsibility for health-promoting behavior. Member incentives may be financial or non-financial, but must be approved by the State. For example, the Plan may offer member incentives for:

- Complying with treatment in a disease management program
- Making healthy lifestyle decisions such as quitting smoking or losing weight

In any member incentive program, the Plan must comply with all marketing provisions in the 42 CFR 438.104, as well as Federal and State regulations regarding inducements. Examples of appropriate rewards include:

- Gift certificates for groceries
- Phone cards
- The establishment and contribution to health care accounts, separate from the POWER Account, to reward healthy behaviors. Such health care accounts can be used by the member to pay for non-covered health care benefits and services, such as over-the-counter drugs, vitamins, gym memberships and other health care items.

8.9.4 Plan Incentive Programs

The State reserves the right to create a performance-based financial incentive plan that can benefit Plans as well as members and providers. If such a plan is implemented, OMPP will identify priority performance improvement areas and incent Plans to achieve graduated performance targets.

9.0 Failure to Perform/Non-compliance Remedies

9.1 Non-compliance Remedies

It is the State's primary goal to ensure that the Plan is delivering quality care to members. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Plan accountable for being in compliance with contract terms. OMPP accomplishes this by working collaboratively with the Plan to maintain and improve programs, and not to impair health plan stability.

In the event that the Plan fails to meet performance requirements or reporting standards set forth in the RFS, any Attachment to the RFS, the contract or other standards established by the State, the State will provide the Plan with a written notice of non-compliance and may require any of the corrective actions or remedies discussed in Section 9.1.1 below. The State will provide written notice of non-compliance to the Plan within 60 calendar days of the State's discovery of such non-compliance.

If OMPP elects not to exercise a corrective action clause contained anywhere in the RFS, any Attachment to the RFS or contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFS, any Attachment to the RFS or contract, may be retroactively assessed.

9.1.1 Corrective Actions

In accordance with 42 CFR 438, Subpart I, OMPP may require corrective action(s) when the Plan has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- Written Warning: OMPP may issue a written warning and solicit a response regarding the Plan's corrective action.

- Formal Corrective Action Plan: OMPP may require the Plan to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the Plan's chief executive and must be approved by OMPP. If the corrective action plan is not acceptable, OMPP may provide suggestions and direction to bring the Plan into compliance.

- Withholding Full or Partial Capitation Payments: OMPP may suspend capitation payments for the following month or subsequent months when the State determines that the Plan is non-compliant. OMPP must give the Plan written notice 10 business days prior to the suspension of capitation payments and specific reasons for non-compliance that result in suspension of payments. The State may continue to suspend all capitation payments until non-compliance issues are corrected.

- Suspending Enrollment: OMPP may suspend the Plan's right to enroll new participants by disallowing self-selection by members and/or auto-assignment of members to the Plan. The State will notify the Plan in writing of its intent to suspend new enrollment at least 10 business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the Plan's ability to cure the default.

- Assigning the Plan's Membership and Responsibilities to Another Plan: The State may assign the Plan's membership and responsibilities to one or more other plans that also provide services to the Program's populations, subject to consent by the plan that would gain that responsibility. The State must notify the Plan in writing of its intent to transfer members and responsibility for those members to another Plan at least 10 business days prior to transferring any members.

- Appointing Temporary Management of the Plan: The State may assume management of the Plan or may assign temporary management of the Plan to the State's agent, if at any time the State determines that the Plan can no longer effectively manage the Plan and provide services to members.

- Contract Termination: The State reserves the right to terminate the contract, in whole or in part, due to the failure of the Plan to comply with any term or condition of the contract, or failure to take corrective action as required by OMPP to comply with the terms of the contract. The State must provide 30 calendar days written notice and must set forth the grounds for termination. See Section 10.1 of this Attachment for the basis upon which the State may terminate the contract.

9.1.2 Liquidated Damages

In the event that the Plan fails to meet performance requirements or reporting standards set forth in the RFS, any Attachment to the RFS, the contract, or other standards set forth by the State, it is agreed that damages shall be sustained by the State, and the Plan shall pay to the State its actual or liquidated damages according to the following subsections and subject to the limitations provided in 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the Plan will pay the State for such failures according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

OMPP may impose remedies resulting from failure of the Plan to provide the requested services depending on the nature, severity and duration of the deficiency. In most cases, liquidated damages will be assessed based on the schedules in Section 9.2 of this Attachment. Should OMPP choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future. OMPP will assess liquidated damages for any of the areas of non-compliance listed in Section 9.2 of this Attachment or for any other areas of non-compliance, at the discretion of OMPP.

9.2 Areas of Non-Compliance

9.2.1 Non-compliance with General Contract Provisions

The objective of this requirement is to provide the State with an administrative procedure to address issues where the Plan is not compliant with the contract. Through routine monitoring, the State may identify contract non-compliance issues. If this occurs, the State will notify the Plan in writing of the nature of the non-performance issue. The State will establish a reasonable period of time, but not more than 10 business days, during which the Plan must provide a written response to the notification. If the Plan does not correct the non-performance issue within the specified time, the State may enforce any of the remedies listed in Section 9.1 of this Attachment.

9.2.2 Non-compliance with Shadow Claims Data Submission

The Plan must comply with the shadow claims submission standards set forth in Section 7.6 of this Attachment. The State will assess liquidated damages on the following elements of shadow claims submissions:

- Batch submission requirements: If the Plan fails to submit all claim types in any given week, the Plan will pay liquidated damages of $5,000 for each month a claim type is not submitted, and will continue to pay damages monthly until the claim type has been submitted.

- Compliance with Pre-Cycle Edits: The Plan's shadow claim submission must pass pre-cycle edits. For each batch submitted, the Plan must reach a 98 percent compliance rate. The State will assess liquidated damages based on an overall average of calendar monthly submissions. For compliance levels lower than 98 percent, the State will assess the following liquidated damages:

Percent of Claims Accepted	Liquidated Damages Amount
93.0 - 97.9	$ 200
88.0 - 92.9	600
83.0 - 87.9	1,000
78.0 - 82.9	1,400
76.0 - 77.9	1,800
0 - 75.9	2,000

In addition, if the Plan's non-compliance continues beyond one month, the State will multiply the amount of the liquidated damages by the number of months of continuing non-compliance. For example, if the Plan's rate of acceptance of shadow claims is below 75 percent for three consecutive months, the State will assess liquidated damages for the third month of non-compliance in the amount of $6,000, or three times the monthly damage amount of $2,000.

- Compliance with accuracy standards: The Plan must document its implementation of policies and procedures to ensure that shadow claims submissions are accurate; that is, that all shadow claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Plan's internal standards and all State and Federal requirements. OMPP reserves the right to review relevant materials, including provider and encounter claims submission and medical records to verify the accuracy of shadow claims. OMPP will require the Plan to submit a corrective action plan and will require non-compliance remedies for the Plan's failure to comply with shadow claims accuracy reporting standards in accordance with Section 7.6.3.

  If the Plan fails to provide accurate submissions the Plan shall pay liquidated damages of $5,000. Payment of liquidated damages does not relieve the Plan of the obligation to provide corrected shadow claim submissions. Substantial deviation between reported and charted encounter data could result in Plan and/or network providers being investigated for potential fraud and abuse.

- Compliance with completeness standards: The Plan must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions. The Plan must also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

  As part of its annual shadow claims work plan, the Plan must demonstrate its internal standards for measuring completeness, the results of any completeness studies and any corrective action plans developed to address areas of non-compliance. OMPP will require the Plan to submit a corrective action plan and will impose non-compliance remedies for the Plan's failure to comply with shadow claims completeness standards in accordance with Section 7.6.3.

  If the Plan fails to provide complete submissions the Plan shall pay liquidated damages of $5,000. Payment of liquidated damages does not relieve the Plan of the obligation to provide completed shadow claim submissions.

9.2.3 Non-compliance with Reporting Requirements

The State will specify the required formats, templates and submission instructions for the reports listed in this Attachment. OMPP may change the frequency of required reports, or may require additional reports, at OMPP's discretion. The State will assess liquidated damages of $200 for each business day past the date due when reports are not delivered complete, on time, and in the correct reporting formats, or submitted incorrectly.

If the Plan's non-compliance with the reporting requirements impacts the State's ability to monitor the Plan's solvency, and the Plan's financial position requires the State to transfer members to another Plan, the Plan must pay any costs the State incurs to accomplish the transfer of members. Further, OMPP will withhold all capitation payments or require corrective action until the Plan provides satisfactory financial data.

9.2.4 Non-compliance with Readiness Review Requirements

If the Plan does not satisfactorily pass the readiness review prior to 30 calendar days before scheduled member enrollment, member enrollment may be delayed, or the State may require other remedies, and the Plan will be responsible for any costs associated with the delay. In addition,

9.2.5 Non-compliance with Performance Requirements

A. **Network Access**. If the Office determines that the Plan has not met the network access standards established in the Scope of Work, the Office shall impose sanctions on the Plan and require submission of a Corrective Action Plan to the Office within ten (10) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of the Plan's Network Geographic Access Assessment Report. Upon the effective date of this Contract, the above-referenced report shall be submitted on a monthly basis until such time as the Office directs the Plan to submit the above-referenced report on a quarterly basis. The Plan will pay liquidated damages as follows: (i) five thousand dollars ($5,000.00) for each reporting period (month or quarter, as the case may be) that the Plan fails to meet the Network Access Standards. Further, should the Plan be liable for liquidated damages for two consecutive reporting periods as a result of failure to meet network access standards, the Office shall immediately suspend auto-enrollment of members with the Plan, until such time as the Plan successfully demonstrates compliance with the network access standards.

B. **Marketing Violations**. If the Office determines that the Plan has violated the requirements of the Plan's obligations with respect to marketing and marketing materials as set forth in Section 4.2 of the Scope of Work, the Plan will pay liquidated damages of one thousand dollars ($1,000.00) for each instance that such determination of a violation is made. For illustration purposes only, a violation will be determined to exist if the Plan distributed, directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Office or that contain inaccurate, false or misleading information.

C. **Claims Payment**. Should the Plan fail to pay clean claims in accordance with

Section 5.9 of this Attachment for two (2) consecutive months, the Office shall immediately suspend auto-enrollment of members with the Plan, until such time as the Plan successfully demonstrates that all past due clean claims have been paid.

D. **Balance Billing.** The Plan must ensure that in-network providers do not balance bill its members (i.e., charge the member for covered services above the amount paid to the provider by the Plan). For each instance where it is established that an in-network provider attempted to balance bill a member, that member's Plan will pay liquidated damages of five hundred dollars $500. In cases where the member failed to alert the in-network provider of their coverage under the Plan, however, liquidated damages will not be assessed.

9.3 Performance Bonds

The Plan must provide a performance bond of standard commercial scope issued by a surety company registered with the IDOI, in the amount of $1,000,000, to guarantee performance by the Plan of its obligations under the contract.

The State reserves the right to increase the required bond amount if enrollment levels indicate the need to do so. In the event of a default by the Plan, the State must, in addition to any other remedies it may have under this contract, obtain payment under the Performance Bond for the purposes of the following:

- Reimbursing the State for any expenses incurred by reason of a breach of the Plan's obligations under this contract, including, but not limited to, expenses incurred after termination of the contract for reasons other than the convenience of the State.

- Reimbursing the State for costs incurred in procuring replacement services.

10.0 Contract Termination and Turnover Provisions

10.1 Contract Terminations

OMPP reserves the right to terminate the contract, in whole or in part, due to the failure of the Plan to comply with any term or condition of the contract, or failure to take corrective action as required by OMPP to comply with the terms of the contract.

The contract between the parties may also be terminated on any of the following bases listed below:

- By mutual written agreement of the State and the Plan.

- By the Plan, subject to the remedies listed in this RFS and its Attachments.

- By the State, in whole or in part, whenever the State determines that the Plan has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within 60 calendar days after receipt of a notice specifying those conditions.

- By the State, in whole or in part, for convenience, with at least 30 calendar days notice to the Plan.

- By the State, in whole or in part, whenever funding from State, Federal, or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Plan.

- By the State, in whole or in part, whenever the State determines that the instability of the Plan's financial condition threatens delivery of covered services under the Program and continued performance of Plan responsibilities.

The State will provide the Plan with a hearing prior to contract termination if termination is imposed as a sanction, in accordance with the standards set forth in 42 CFR 438.710.

10.1.1 Termination by the State

The State may terminate the contract, in whole or in part, whenever the State determines that the Plan or subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within 60 calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination must be referred to herein as "Termination for Default."

Upon determination by the State that the Plan has failed to satisfactorily perform its contracted duties and responsibilities, the Plan must be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Plan is unable to cure the failure within the specified time period, the State will notify the Plan that the contract, in full or in part, has been terminated for default.

If, after notice of termination for default, it is determined by the State or by a court of law that the Plan was not in default or that the Plan's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Plan or any of its subcontractors, the notice of termination must be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties must be governed accordingly.

In the event of termination for default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Plan shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Plan shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a termination for default prior to the start of operations, any claim the Plan may assert must be governed by the procedures defined in this RFS.

In the event of a termination for default during ongoing operations, the Plan will be paid for any outstanding capitation payments due, less any assessed damages.

The rights and remedies of the State provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the contract.

10.1.2 Termination for Financial Instability

OMPP may terminate the contract immediately upon the occurrence of any of the following events:

- The Plan becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the contract
- The Plan ceases to conduct business in normal course
- The Plan makes a general assignment for the benefit of creditors
- The Plan suffers or permits the appointment of a receiver for its business or assets

The State may, at its option, immediately terminate the contract effective at the close of business on the date specified. In the event the State elects to terminate the contract under this provision, the Plan must be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Plan must immediately so advise the Contract Administrator as specified in the contract between the State and the Plan. The Plan must ensure that all tasks related to the subcontract are performed in accordance with the terms of this contract.

10.1.3 Termination for Failure to Disclose Records

The State may terminate the contract, in whole or in part, whenever the State determines that the Plan has failed to make available to any authorized representative of the State, any administrative, financial and medical records relating to the delivery of services for which State Medicaid program dollars have been expended.

In the event that the State terminates the contract pursuant to this provision, the Plan must be notified in writing, either by certified or registered mail, either 60 calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination must be effective as of the close of business on the date specified in the notice.

10.1.4 Termination by the Plan

The Plan must give advance written notice of termination, or intent not to renew, to the State a minimum of 180 calendar days prior to termination. The effective date of the termination must be the last day of the month in which the 180th day falls. Termination of the contract by the Plan is subject to damages listed in Section 10.4 of this Attachment.

In the event of termination by the Plan, the Plan must submit within 10 days of the Plan's notification to the State of its intent to terminate the contract, a written termination plan for the State's approval, describing what actions it will take to address each of the issues detailed in Section 10.2 of this Attachment. The requirements listed in Section 10.2 are illustrative only and do not limit or restrict the State's ability to require the Plan to address additional issues in its Termination Plan.

10.2 Termination Procedures

When termination is anticipated, OMPP will deliver to the Plan a Notice of Termination by certified or registered mail specifying the nature of the termination and the date upon which such termination becomes effective. Upon receipt of the Notice of Termination, the Plan must develop and submit a Termination Plan for OMPP's approval that, at minimum, addresses the requirements listed below. The

following requirements are illustrative only and do not limit or restrict the State's ability to require the Plan to address additional issues in its Termination Plan.

- Stopping work under the contract, on the date and to the extent specified in the Notice of Termination.
- Placing no further orders or subcontracts for materials, services or facilities.
- Notifying all of the Plan's members regarding the date of termination and the manner in which, and extent to which, members will continue to receive medical care, have access to POWER Account funds and have use of their POWER Account card. OMPP must approve all member notification materials in advance of distribution.
- Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning to the State, its designee or successor contractor, in the manner and to the extent directed, all of the rights, titles, and interests of the Plan under the orders or subcontracts so terminated.
- With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.
- With the approval of the State, establishing a plan for transferring member POWER Account funds and related information to the State, its designee or the successor contractor.
- Within 10 business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination, including up-to-date performance data as requested pursuant to Section 8 of this Attachment.
- Completing the performance of such part of work that has not been specified for termination by the Notice of Termination.
- Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the contract that is in the possession of the Plan and in which the State has or may acquire an interest.

10.3 Plan Responsibilities Upon Termination

Termination of the contract does not discharge the obligations of the Plan with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. Termination does not discharge the State's payment obligations to the Plan or the Plan's payment obligations to its subcontractors and providers.

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The State intends to ensure that, to the greatest extent possible, members, providers and other interested parties, experience no adverse impact due to termination of the contract. Upon termination of the contract, the Plan must:

- Within ten days of Notice of Termination, provide a written termination plan, as identified in Section 10.2 above, for the State's approval. The Plan will revise and resubmit the termination plan to the State on a regular basis, the frequency of which will be determined by the State.

- As outlined and approved by the State in the written termination plan, assist the State in taking the necessary steps to ensure a smooth transition of Requested Services after receipt of the Notice of Termination.

- In a format specified by the State, provide the State with all information deemed necessary by the State within 30 calendar days of the request, including up-to-date data about member utilization of recommended preventative services and requested performance data pursuant to Section 8 of this Attachment.

- Be financially responsible for all claims with dates of service through the day of termination, including those submitted within established time limits after the day of termination.

- Be responsible for submitting all shadow claims to the State for a period of time not less than fifteen months after termination.

- Be financially responsible for hospitalized patients through the date of discharge.

- Be financially responsible for services rendered through the day of termination, for which payment is denied by the Plan and subsequently approved upon appeal by the provider.

- Be financially responsible for member appeals of adverse decisions rendered by the Plan concerning treatment of services requested prior to termination which are subsequently upheld on behalf of the member after an appeal proceeding or after a State Fair Hearing.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Plan must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.

- Notify all members about the contract termination and the process by which members will continue to receive medical care, at least 60 calendar days in advance of the effective date of termination. The Plan will be responsible for all expenses associated with member notification. OMPP must approve all member notification materials in advance of distribution.

- Notify all members about the manner in which, and extent to which, members will have access to POWER Account funds and use of their POWER Account card. The Plan will be responsible for all expenses associated with member notification. OMPP must approve all member notification materials in advance of distribution.

- Notify all providers about the contract termination and the process by which members will continue to receive medical care, at least 60 calendar days in advance of the effective date of termination. The Plan will be responsible for all expenses associated with provider notification. OMPP must approve all provider notification materials in advance of distribution.

- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Comply with any additional items the State required the Plan to address in its Termination Plan.

10.4 Assignment of Terminating Plan's Membership and Responsibilities

If the contract is terminated under this Section, the State may assign the Plan's membership and responsibilities to one or more other plans that also provide services to the Program's populations, subject to consent by the plan that would gain the member enrollment. OMPP will develop a transition plan should it choose to terminate or not extend a contract with one or more plans providing services to members in the Program.

In the event that OMPP assigns members or responsibility to another plan, during the final quarter of the contract, the Plan will work cooperatively with, and supply program information to, any subsequent plans. Both the program information and the working relationship among the plans will be defined by the State.

10.5 Plan Turnover

In the event of non-renewal of the contract (or failure of the State and the Plan to enter into a new contract pursuant to subsequent procurements for the Program), the State intends to ensure that, to the greatest extent possible, members, providers and other interested parties experience no adverse impact due to the transfer of Program services from the Plan to either the State or to a successor contractor. For this reason, the Plan must give advance written notice of its intent not to renew the contract, or intent not to participate in a reprocurement for the Program, to the State a minimum of 180 calendar days prior to contract expiration.

Before expiration of the contract, the Plan will be required to submit a Turnover Plan to the State. The Turnover Plan must be a comprehensive document that details the proposed schedule and activities associated with transferring Program services from the Plan to the State or its successor contractor. The Turnover Plan must address the issues set forth in Section 10.2 above. The requirements listed in Section 10.2 are illustrative only and do not limit or restrict the State's ability to require the Plan to address additional issues in its Turnover Plan.

The Plan will be required to develop and submit a Turnover Plan for OMPP's approval within:

- 10 days after providing notice of its intent not to renew the contract or intent not to participate in a reprocurement under the Program; or
- 20 days after receiving notice of the State's intention not to renew the contract or enter into a new contract.

The responsibilities set forth in Sections 10.3 and 10.4 above shall apply to the Plan upon contract expiration in the same manner that they apply to the Plan upon contract termination.

10.6 Damages

The Plan acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Plan acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into this contract, including expenses relating to training staff, data collection and processing, actuarial determination of capitation rate, and ongoing changes to the State's and the fiscal agent's management information systems. The Plan further acknowledges and agrees that in the event this contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Plan or due to the Plan's failure to fully comply with the terms and conditions of this contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Plan accordingly agrees that the State may, in such event, seek and obtain injunctive relief, as well as actual damages.

The remedies available to the State under this Agreement include but are not limited to:

- Obtaining payment under the Performance Bond
- Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Plan. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition.
- Liquidated damages equal to one percent of the maximum monthly capitation payment the Plan has received under the contract multiplied by the number of months of the contract term remaining after the effective date of termination

Payment of the Performance Bond is due within 10 calendar days of the date of termination. Payment of liquidated damages is due within 30 calendar days from the date of termination. Payment of actual damages is due within 10 calendar days of the Plan's receipt of the State's demand for payment.

10.7 Refunds of Advanced Payments

The Plan must, within 30 calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the contract.

10.8 Termination Claims

If the contract is terminated under this section, the Plan must be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which notice of termination was received for the service days prior to the effective date of termination. The Plan will have the right of appeal, as stated under the subsection on Disputes in the contract, of any such determination. The Plan will not be entitled to payment of any services performed after the effective date of termination.